

CERTIFICATE OF DEATH

Reg. Dist. No.

01179

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| 1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>10+ YRS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - SHARPSBURG</u> d. STREET ADDRESS <u>ROUTE #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>NEHEMIAH</u> Last <u>ABBOTT</u> | | 4. DATE OF DEATH Month <u>JAN</u> Day <u>18</u> Year <u>1958</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 19, 1882</u> |
| 9. AGE (In years last birthday) yrs. <u>75</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA, U.S.A.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>SINNET NEHEMIAH ABBOTT</u> | |
| 14. MOTHER'S MAIDEN NAME <u>ELIZABETH FRANCES GROVE</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT Address <u>PETER SIMEON ABBOTT BOONSBORO ROUTE 1</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>PULMONARY EMBOLI & INFARCTS</u> (c) <u>ARTERIOSCLEROTIC & HYPERTENSIVE CARDIOVASCULAR DISEASE</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 DYS.</u> <u>UNKNOWN</u> <u>7 YRS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>AORTIC & MITRAL VALVULITIS - RHEUMATIC - HEALED.</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>NOV. 11, 1957</u> , to <u>JAN. 18, 1958</u> , that I last saw the deceased alive on <u>JAN. 18, 1958</u> , and that death occurred at <u>7:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>WESTERN MARYLAND STATE HOSPITAL</u> DATE SIGNED <u> </u> | | | |
| ACTUAL SIGNATURE <u>George Bercu, M.D.</u> | | PHYSICIAN'S NAME (Type) <u>DR. GEORGE BERCU</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>Jan 26/1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Cemetery</u> |
| 22d. LOCATION (City, town, or county) (State) <u>Surry, Virginia</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Md</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>JAN 22 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. Search</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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|---------------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF CORONER | |
| 16. SIGNATURE OF JUDGE | | 17. SIGNATURE OF CLERK | | 18. SIGNATURE OF SHERIFF | |
| 19. SIGNATURE OF DEPUTY SHERIFF | | 20. SIGNATURE OF CONSTABLE | | 21. SIGNATURE OF JURY | |
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RECEIVED
JAN 25 1958
BUREAU V. S.

1188

CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | | c. LENGTH OF STAY IN 1b 10 WEEKS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO | | | |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle S Last ASHBAUGH | | | | 4. DATE OF DEATH JANUARY 18 1958 19 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JUNE 21 1891 | |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) ROHRERSVILLE WASH.CO.MD. U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME JACOB BOYER | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH McBRIDE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT GEORGE E. ASHBAUGH Jr. BOONSBORO MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adgkin's Disease 201x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 Diabetic Mellitus | | | | INTERVAL BETWEEN ONSET AND DEATH 12 mos | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Aug 15, 1958 to Jan 18, 1958 , that I last saw the deceased alive on Jan 18, 1958 , and that death occurred at 10:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 217 W. Washington Street DATE SIGNED 1/20/58 | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto III M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D. Hagerstown, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF JANUARY 21 1958 | | 22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY BOONSBORO WASH.CO.MD. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ward Funeral Home Boonsboro Md. | | | | 24a. REC'D BY REGISTRAR DATE JAN 22 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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|------------------------|--|------|--|-------|--|---------|--|---------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | |
| JACOB W. ... | | ... | | ... | | ... | | ... | |
| PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | | DATE OF BIRTH | |
| ... | | ... | | ... | | ... | | ... | |
| OCCUPATION | | ... | | ... | | ... | | ... | |
| ... | | ... | | ... | | ... | | ... | |
| CAUSE OF DEATH | | ... | | ... | | ... | | ... | |
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| MANNER OF DEATH | | ... | | ... | | ... | | ... | |
| ... | | ... | | ... | | ... | | ... | |
| SIGNATURE OF PHYSICIAN | | ... | | ... | | ... | | ... | |
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| SIGNATURE OF REGISTRAR | | ... | | ... | | ... | | ... | |
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BUREAU V. S.

JAN 22 1938

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WEST VIRGINIA</u> b. COUNTY <u>NEW CREEK</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAN MAR</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW CREEK</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAHRNEY KEEDY MEMORIAL HOME</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>BAKER</u> Last <u>BAKER</u> | | | | 4. DATE OF DEATH Month <u>JANUARY</u> Day <u>7</u> Year <u>1958</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DECEMBER 31 1869</u> | 9. AGE (In years lost birthday) <u>88</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | | 11. BIRTHPLACE (State or foreign country) <u>NEW CREEK WEST VIRGINIA U.S.A.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>MILTON BAKER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>PHADELIA WILT</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>RECORDS FAHRNEY KEEDY HOME BOONSBORO MD.</u> Address <u>R 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Decompression of heart</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>1 wk.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>Sept 1, 1957</u> to <u>Jan 7, 1958</u> , that I last saw the deceased alive on <u>Jan 7, 1958</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>G. W. H. Van</u> | | | | ADDRESS (Street, city or town, state) <u>Boonsboro Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>G. W. H. Van</u> | | | | DATE SIGNED <u>1-7-58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan 10, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Lawrenceville W. Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Rogers Funeral Home - Keyser, W. Va.</u> ADDRESS _____ | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 10 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1953

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| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | | 3. AGE [Faint text] | | 4. DATE OF BIRTH [Faint text] | | 5. PLACE OF BIRTH [Faint text] | | 6. MARITAL STATUS [Faint text] | | 7. OCCUPATION [Faint text] | | 8. CAUSE OF DEATH [Faint text] | | 9. MANNER OF DEATH [Faint text] | | 10. SIGNATURE OF PHYSICIAN [Faint text] | | 11. SIGNATURE OF REGISTRAR [Faint text] | | 12. SIGNATURE OF WITNESSES [Faint text] | |
| 13. PLACE OF DEATH [Faint text] | | 14. DATE OF DEATH [Faint text] | | 15. TIME OF DEATH [Faint text] | | 16. PLACE OF INTERMENT [Faint text] | | 17. DATE OF INTERMENT [Faint text] | | 18. TIME OF INTERMENT [Faint text] | | 19. NAME OF INTERMENT PLACE [Faint text] | | 20. NAME OF MINISTER [Faint text] | | 21. NAME OF CHURCH [Faint text] | | 22. NAME OF FUNERAL HOME [Faint text] | | 23. NAME OF CEMETERY [Faint text] | | 24. NAME OF BURIAL PLACE [Faint text] | |
| 25. NAME OF NEXT OF KIN [Faint text] | | 26. ADDRESS OF NEXT OF KIN [Faint text] | | 27. CITY OF NEXT OF KIN [Faint text] | | 28. STATE OF NEXT OF KIN [Faint text] | | 29. COUNTRY OF NEXT OF KIN [Faint text] | | 30. NAME OF NEXT OF KIN [Faint text] | | 31. ADDRESS OF NEXT OF KIN [Faint text] | | 32. CITY OF NEXT OF KIN [Faint text] | | 33. STATE OF NEXT OF KIN [Faint text] | | 34. COUNTRY OF NEXT OF KIN [Faint text] | | 35. NAME OF NEXT OF KIN [Faint text] | | 36. ADDRESS OF NEXT OF KIN [Faint text] | |
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| 85. NAME OF NEXT OF KIN [Faint text] | | 86. ADDRESS OF NEXT OF KIN [Faint text] | | 87. CITY OF NEXT OF KIN [Faint text] | | 88. STATE OF NEXT OF KIN [Faint text] | | 89. COUNTRY OF NEXT OF KIN [Faint text] | | 90. NAME OF NEXT OF KIN [Faint text] | | 91. ADDRESS OF NEXT OF KIN [Faint text] | | 92. CITY OF NEXT OF KIN [Faint text] | | 93. STATE OF NEXT OF KIN [Faint text] | | 94. COUNTRY OF NEXT OF KIN [Faint text] | | 95. NAME OF NEXT OF KIN [Faint text] | | 96. ADDRESS OF NEXT OF KIN [Faint text] | |
| 97. NAME OF NEXT OF KIN [Faint text] | | 98. ADDRESS OF NEXT OF KIN [Faint text] | | 99. CITY OF NEXT OF KIN [Faint text] | | 100. STATE OF NEXT OF KIN [Faint text] | | 101. COUNTRY OF NEXT OF KIN [Faint text] | | 102. NAME OF NEXT OF KIN [Faint text] | | 103. ADDRESS OF NEXT OF KIN [Faint text] | | 104. CITY OF NEXT OF KIN [Faint text] | | 105. STATE OF NEXT OF KIN [Faint text] | | 106. COUNTRY OF NEXT OF KIN [Faint text] | | 107. NAME OF NEXT OF KIN [Faint text] | | 108. ADDRESS OF NEXT OF KIN [Faint text] | |
| 109. NAME OF NEXT OF KIN [Faint text] | | 110. ADDRESS OF NEXT OF KIN [Faint text] | | 111. CITY OF NEXT OF KIN [Faint text] | | 112. STATE OF NEXT OF KIN [Faint text] | | 113. COUNTRY OF NEXT OF KIN [Faint text] | | 114. NAME OF NEXT OF KIN [Faint text] | | 115. ADDRESS OF NEXT OF KIN [Faint text] | | 116. CITY OF NEXT OF KIN [Faint text] | | 117. STATE OF NEXT OF KIN [Faint text] | | 118. COUNTRY OF NEXT OF KIN [Faint text] | | 119. NAME OF NEXT OF KIN [Faint text] | | 120. ADDRESS OF NEXT OF KIN [Faint text] | |

BUREAU V. S.

JAN 10 1953

RECEIVED

1189 CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | | c. LENGTH OF STAY IN lb 10 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ohmer Clayton Beachley | | | | 4. DATE OF DEATH Month Day Year January 13 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 8, 1884 | |
| 9. AGE (In years lost birthday) 73 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher | | 11. BIRTHPLACE (State or foreign country) Fairplay, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles E. Beachley | | | | 14. MOTHER'S MAIDEN NAME Laura Huntzberry | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 219-14-8295 A | | 17. INFORMANT Mrs. Esther Beachley | | Address Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral arteriosclerosis and hypertensive cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 days 2 yrs. 9 mos. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystitis, pyelitis ---duration 8 days | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Hagerstown | | | | 20g. (County) Maryland | | 20h. (State) Maryland | |
| 21. I certify that I attended the deceased from January 3, 1958 , to January 13 1958 , that I last saw the deceased alive on January 12, 1958 , and that death occurred at 6:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. DATE SIGNED 1/13/58 | | | | | | | |
| ACTUAL SIGNATURE <i>W. T. Layman</i> | | | | M.D. 100 Professional Arts Bldg. 1/13/58 | | | |
| PHYSICIAN'S NAME (Type) William T. Layman | | | | Hagerstown Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/16/1958 | | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Franklin Rorer</i> | | | | ADDRESS Hagerstown, Md. | | 24a. REC'D BY REGISTRAR DATE JAN 15 '58 | |
| 24b. REGISTRAR'S SIGNATURE <i>Alfred</i> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise.

BUREAU V. S.

JAN 15 1939

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1190

CERTIFICATE OF DEATH

01183

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | | c. LENGTH OF STAY IN 1b LIFE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | | | d. STREET ADDRESS 134 ELIZABETH ST. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM EDWARD BLENARD | | | | 4. DATE OF DEATH Month Day Year JANUARY 28 1958 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/14/1889 | |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BOILER MAKER | | 10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME CHRISTIAN BLENARD | | | | 14. MOTHER'S MAIDEN NAME SUSAN BESECKER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 705-10-6819 | | 17. INFORMANT MRS. MARY E. BLENARD | | Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebotrombosis of leg DUE TO (c) Carcinoma of abdomen | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 minutes 1 wk. 3 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I attended the deceased from Nov 1957 to 28 Jan 1958 , that I last saw the deceased alive on 28 Jan 1958 , and that death occurred at 1230 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 W. Wash. St. Hagerstown Md. DATE SIGNED 1/29/58 | | | | | | | |
| ACTUAL SIGNATURE E. J. Hoachlander | | PHYSICIAN'S NAME (Type) E. J. Hoachlander Hagerstown Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 1/30/58 | | 22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | | 22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR DATE JAN 31 '58 | | 24b. REGISTRAR'S SIGNATURE Alfred... | |

CERTIFICATE OF DEATH

Page One of Two

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BUREAU V. 2

JAN 31 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1191

CERTIFICATE OF DEATH

01184

Reg. Dist. No. 302

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | | c. LENGTH OF STAY IN 1b <u>6 Weeks</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES NMN BRILLHART</u> | | | | 4. DATE OF DEATH Month Day Year <u>Jan 14 1958 19</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug 27 1875</u> | |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Porter Chem Co</u> | | 11. BIRTHPLACE (State or foreign country) <u>Dauphin Co Boiling Springs Penna</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>John Brillhart</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>No Record</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>217-18-8997</u> | | | | 17. INFORMANT Address <u>Mrs Sarah Wiley 128 High St</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>+ cerebral thrombosis</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonic hypertrophy</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Aug 10</u> , 1956, to <u>Jan 14</u> , 1958, that I last saw the deceased alive on <u>Jan 14</u> , 1958, and that death occurred at <u>9:57</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 W. Washington Street</u> DATE SIGNED <u>1/14/58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D. <u>Hagerstown, Maryland</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Edward W. Ditto 111, M.D. Hagerstown, Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>1/16/58</u> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> | | | | 24a. REC'D BY REGISTRAR <u>JAN 16 1958</u> 24b. REGISTRAR'S SIGNATURE | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JAN 1933

RECEIVED

1240

CERTIFICATE OF DEATH

Reg. Dist. No. 1185

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEAVER CREEK | | | c. LENGTH OF STAY IN 1b LIFE | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAGERSTOWN MD. R. 1 | | | d. STREET ADDRESS HAGERSTOWN MD. R. 1 | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HARRY E. BRINING | | | 4. DATE OF DEATH Month Day Year JANUARY 30 1958 19 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MARCH 17 1900 | | 9. AGE (In years lost birthday) yrs. 57 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROAD SUPERVISOR WASH. CO. ROAD DEPT. | | 10b. KIND OF BUSINESS OR INDUSTRY BEAVER CREEK WASH. CO. MD. | | 11. BIRTHPLACE (State or foreign country) U.S.A. | |
| 13. FATHER'S NAME WILLIAM BRINING | | | 14. MOTHER'S MAIDEN NAME KATIE RUDY | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 244-09-3596 | | 17. INFORMANT MRS. ILEIDA BRINING HAGERSTOWN MD. R. 1 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic Heart Disease</i> DUE TO (c) <i>6 yrs</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 12-1-1917 , to 1-30-1958 , that I last saw the deceased alive on 1-29-58 , and that death occurred at 3 P.M. from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <i>S. W. Smith</i> | | ADDRESS (Street, city or town, state) <i>Hagerstown Md</i> | | DATE SIGNED <i>1/31/58</i> | |
| PHYSICIAN'S NAME (Type) <i>S. W. Smith</i> | | ADDRESS <i>Hagerstown Md</i> | | DATE SIGNED <i>1/31/58</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF FEBRUARY 2 1958 | | 22c. NAME OF CEMETERY OR CREMATORY MT. LENA CEMETERY | |
| 22d. LOCATION (City, town, or county) MT. LENA WASH. CO. MD. | | 22e. (State) MD. | | 22f. (Country) U.S.A. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Barb Funn Home</i> | | ADDRESS <i>Boonsboro Md</i> | | 24a. REC'D BY REGISTRAR <i>1958</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>1958</i> | | 24c. DATE <i>1958</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

FEB 5 1923

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG224 1-8-58 et

CERTIFICATE OF DEATH

Reg. Dist. No. 01186

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN TB <u>7 Weeks</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u> | | e. STREET ADDRESS <u>118 So Locust St</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA</u> <u>FRANCES</u> <u>BURGAN</u> | | 4. DATE OF DEATH Month Day Year <u>Jan</u> <u>1</u> <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>X</u> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1884</u> <u>June 11 1883</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Irvin Grimm</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Hilling</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Theodore E. Burgan</u> | | Address <u>330 So Main St</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia - debilitation - Collapse</u> 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lymphoma</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u> <u>2 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> <u>Coronary Artery Disease</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>OCT 31</u> , 19 <u>56</u> to <u>1/1/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/1/58</u> , 19 <u>58</u> , and that death occurred at <u>119 C. Antietam</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Louis G. Gratt</u> M.D. <u>1/2/58</u> PHYSICIAN'S NAME (Type) <u>Louis G. Gratt</u> <u>Hagerstown, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/4/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> | | ADDRESS <u>Hagerstown Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>1/2/58</u> | | 24b. REGISTRAR'S SIGNATURE <u>A. Hedrick</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01187

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | c. LENGTH OF STAY IN 1b 36 yrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20 Garlinger Ave. | | d. STREET ADDRESS 20 Garlinger Ave. | |
| 3. NAME OF DECEASED (Type or print) First NOAH Middle SYLVESTER Last BURKER | | 4. DATE OF DEATH Month Jan. Day 24 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Dec. 16, 1892 |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker | | 10b. KIND OF BUSINESS OR INDUSTRY Building | 11. BIRTHPLACE (State or foreign country) Luray, Va. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Thomas Lee Burkner | |
| 14. MOTHER'S MAIDEN NAME Jennie Breeden | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 220-05-6730 | | 17. INFORMANT Address Mr. Geo Burkner 318 Linganore Ave. Hagerstown, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Cervical Vertebrae 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002K Tuberculosis of Lung | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently fell down stair-steps at home while going to bathroom | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. Jan. 24 1958 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home | 20f. (City or town) Hagerstown (County) Wash (State) Md |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/27/58 | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery |
| | | 22d. LOCATION (City, town, or county) Hagerstown | (State) Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rest Haven Funeral Chapel Inc. 1601 Penna. Ave. Hagerstown, Md. | | 24a. REC'D BY REGISTRAR JAN 28 1958 | 24b. REGISTRAR'S SIGNATURE [Signature] |

Wm. A. Stant O-Pros.

THE STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

RACE OF DECEASED

EDUCATION OF DECEASED

OCCUPATION OF DECEASED

RELATIONSHIP OF DECEASED TO REPORTER

RESIDENCE OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

RACE OF DECEASED

EDUCATION OF DECEASED

OCCUPATION OF DECEASED

RELATIONSHIP OF DECEASED TO REPORTER

RESIDENCE OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

RACE OF DECEASED

EDUCATION OF DECEASED

OCCUPATION OF DECEASED

RELATIONSHIP OF DECEASED TO REPORTER

RESIDENCE OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

RACE OF DECEASED

EDUCATION OF DECEASED

OCCUPATION OF DECEASED

RELATIONSHIP OF DECEASED TO REPORTER

RESIDENCE OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

RACE OF DECEASED

EDUCATION OF DECEASED

OCCUPATION OF DECEASED

RELATIONSHIP OF DECEASED TO REPORTER

RESIDENCE OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

RACE OF DECEASED

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RACE OF DECEASED

EDUCATION OF DECEASED

OCCUPATION OF DECEASED

RELATIONSHIP OF DECEASED TO REPORTER

RESIDENCE OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

BUREAU V. R.

JAN 28 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| BALTIMORE, 18 | | | | | | | | | | 01188 | | |
|--|--|-----------------------|---|---|---|--|--|--|---|---|--------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. | | |
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland | | | c. LENGTH OF STAY IN 1b 6 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hancock | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | | | | d. STREET ADDRESS 218 Maryland Ave. | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Virginia Elizabeth Burnett | | | | | 4. DATE OF DEATH Month Day Year 1 25 19 58 | | | | | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8.25.1922 | | 9. AGE (In years last birthday) 35 yrs. 8 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | | 11. BIRTHPLACE (State or foreign country) Morgan County W.VA. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Lorne Bohrer | | | | | 14. MOTHER'S MAIDEN NAME Leona Bohrer | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. [If yes, give war or dates of service] | | 17. INFORMANT Charles R Burnett Hancock Maryland. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cellulitis & septicemia (undiagnosed organism) 900.0 Undetermined Yet DUE TO secondary to laceration (b) of rt knee Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Terminal hemorrhagic esophagitis (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while going up icy steps to home | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 11:15 p.m. Jan. 15 1958 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) Hancock | | 20g. (County) Wash | | 20h. (State) Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE S. Robert Wells | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | DATE SIGNED | | |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | Jan. 28 '58 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Type) Burial | | | 22b. DATE THEREOF 1.29.58 | | 22c. NAME OF CEMETERY OR CREMATORY Union Chapel | | | 22d. LOCATION (City, town, or county) (State) Berkeley Springs W.V.A. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone | | | | | ADDRESS Hancock Md | | 24a. REC'D BY REGISTRAR DATE JAN 31 '58 | | 24b. REGISTRAR'S SIGNATURE O. J. Leach | | | |

STATE AND STATE DEPARTMENT OF HEALTH - JANUARY 1938
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|----------------------------------|--|-----------------|--|---|--|-----------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | |
| JAMES H. HANCOCK | | 45 | | M | | W | | JAN 31 1938 | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | |
| 1000 N. 10th St. St. Paul, Minn. | | Salesman | | Myocardial Infarction | | Natural | | Home | |
| DATE OF BIRTH | | PLACE OF BIRTH | | EDUCATION | | MARITAL STATUS | | RELIGION | |
| JAN 1 1893 | | St. Paul, Minn. | | High School | | Married | | Roman Catholic | |
| PREVIOUS ILLNESS | | TREATMENT | | HISTORY OF PRESENT ILLNESS | | FAMILY HISTORY | | SOCIAL HISTORY | |
| None | | None | | Sudden onset of chest pain, radiating to left arm, associated with sweating and nausea. | | None | | None | |
| TESTS | | X-RAY | | AUTOPSY | | LABORATORY | | OTHER | |
| None | | None | | None | | None | | None | |

BUREAU V. 3

JAN 31 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01189

1241

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown rural | | c. LENGTH OF STAY IN TB life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. # 4 | | | | d. STREET ADDRESS R.F.D. # 4 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First David Middle Howard Last Carr | | | | 4. DATE OF DEATH Month 1 Day 12 Year 19 58 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 24, 1957 | | 9. AGE (in years last birthday) 8 yrs. | IF UNDER 1 YEAR Months 8 Days 12 Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | | 10b. KIND OF BUSINESS OR INDUSTRY infant | | 11. BIRTHPLACE (State or foreign country) Wash. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Jay B. Carr | | | | 14. MOTHER'S MAIDEN NAME Mary K. Howard | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Jay Carr Hagerstown R 4 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus (sudden death) 543X DUE TO Gastritis - cause unknown Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO _____ cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. none p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE S. Robert Wells | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 1-14-58 | | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven | | 22d. LOCATION (City, town, or county) (State) Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown Md. | | | | ADDRESS | | 24a. REC'D BY REGISTRAR JAN 15 '58 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Deborah | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, filing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2081378XV6

BUREAU V. 5

JAN 15 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01190

Reg. Dist. No.

1195

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 10 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 626 Salem Ave., | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 626 Salem Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Louis Middle Godfred Last Castang | | 4. DATE OF DEATH Month 1 Day 11 Year 19 58 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-5-1883 |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months 74 Days 74 | IF UNDER 24 HRS. Hours 74 Min. 74 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10b. KIND OF BUSINESS OR INDUSTRY farmer | |
| 11. BIRTHPLACE (State or foreign country) Atwood, Ill. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Louis Castang | | 14. MOTHER'S MAIDEN NAME Emma Wilson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. W.W. I 353-18-5264 | |
| 17. INFORMANT Mrs. Olive R. Castang | | Address Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Diabetes M Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) - (County) - (State) - | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-14-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rose Hill | | 22d. LOCATION (City, town, or county) Hagerstown (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss | | ADDRESS Hagerstown, Md. | |
| 24a. REC'D BY REGISTRAR JAN 15 58 | | 24b. REGISTRAR'S SIGNATURE W. H. Hager | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01191

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN 1b <u>40 yrs</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>137 N. Jonathan St</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Clark</u> Last <u>Clark</u> | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>5</u> Year <u>58</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1891</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Comfort Station</u> | 11. BIRTHPLACE (State or foreign country) <u>Berryville, Virginia</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Unknew</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Unknew</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>World War #1</u> | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Rose Jackson Winchester Va.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic myocardial heart disease</u> <u>422.1</u> DUE TO <u>with myocardial failure grade iv</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u> | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>S. Robert Wells</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-7-58</u> | |
| EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 22b. DATE THEREOF <u>Jan. 7, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Winchester, Va.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Watson Jr. Hagerstown Md.</u> | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 9 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u> </u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 9 1938

BUREAU V. S.

1197

CERTIFICATE OF DEATH

01192

Reg. Dist. No.

| | | | |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 52 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 753 W. Washington St., | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First H Middle Zelene Last Clark | | 4. DATE OF DEATH Month 1 Day 3 Year 19 58 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 21, 1883 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | |
| 11. BIRTHPLACE (State or foreign country) Wilson District, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John B. Huyett | | 14. MOTHER'S MAIDEN NAME Mary E. Downin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT David E. Clark | | Address Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 3 mo. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 2, 1958 , to Jan 3, 1958 , that I last saw the deceased alive on Jan 3, 1958 , and that death occurred at 8 A. M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Lloyd A. Hoffman | | ADDRESS (Street, city or town, state) 214 N. Potomac St. Hagerstown, Md. | |
| DATE SIGNED 1/6/58 | | | |
| PHYSICIAN'S NAME (Type) Lloyd A. Hoffman | | Hagerstown, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | 22b. DATE THEREOF 1-6-58 | 22c. NAME OF CEMETERY OR CREMATORY Rose Hill | 22d. LOCATION (City, town, or county) (State) Hagerstown Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss | | ADDRESS Hagerstown, Md. | |
| 24a. REC'D BY REGISTRAR DATE JAN 8 '58 | | 24b. REGISTRAR'S SIGNATURE W. H. Beach | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1242

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Route 1</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Route 1 Clear Spring, Md.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u> | | | | d. STREET ADDRESS <u>None</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>SAMUEL</u> Last <u>CUNNINGHAM</u> | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>October 11, 1876</u> | |
| 9. AGE (In years lost birthday) yrs. <u>81</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u> | | 11. BIRTHPLACE (State or foreign country) <u>Washington County</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Samuel Cunningham</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Susan Brash</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>214-09-8862</u> | | 17. INFORMANT <u>Mrs Viola Angle</u> Address <u>Route 1 Clear Spring, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Endocarditis</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterial Sclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>10 yrs.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Oct 1, 1957</u> , to <u>Jan 4, 1958</u> , that I last saw the deceased alive on <u>Jan 4, 1958</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>1/6/58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>David R. Brewer</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>David R. Brewer</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 7, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u> ADDRESS <u>Clear Spring, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 8 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Al Schuch</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

JAN 8 1958

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1198

CERTIFICATE OF DEATH

Dr Paoker

01194

Reg. Dist. No. 302

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN 1b <u>12 Yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2321 Virginia Ave</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>Blain</u> Last <u>Dellinger</u> | | 4. DATE OF DEATH Month <u>Jan</u> Day <u>22</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 14, 1884</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Near Downsville Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jacob Dellinger</u> | | 14. MOTHER'S MAIDEN NAME <u>Laura Snyder</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. <u>Mrs. Sarah Grace Dellinger</u> | |
| 17. INFORMANT <u>Mrs. Sarah Grace Dellinger</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension arteriosclerotic</u> DUE TO (c) <u>vascular disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>Unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 22, 1957</u> , to <u>Jan 21, 1958</u> , that I last saw the deceased alive on <u>Jan 22, 1958</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>L. L. Paoker</u> M.D. | | ADDRESS (Street, city or town, state) <u>145 W. Washington St. Hagerstown, Md.</u> | |
| DATE SIGNED <u>1/22/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>L. L. Paoker Dr.</u> | | <u>Hagerstown, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan 24/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> | | ADDRESS <u>Hagerstown, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>Jan 28 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Dr. Paoker</u> | |

CERTIFICATE OF DEATH

BUREAU V. 2

JAN 28 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1199
Dr. Hornbaker

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

01195

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 1 week | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital | | d. STREET ADDRESS / 341 East Irvin Ave. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HANNAH BELL DIETRICH | | 4. DATE OF DEATH Month Day Year January 20, 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 12, 1878 |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Mother | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (State or foreign country) Md. Burkettsville, Fred. Co. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Amos Brandenburg | | 14. MOTHER'S MAIDEN NAME Alice Lakin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-30-9891 | |
| 17. INFORMANT Mrs. Charlotte Stone-341 E. Irvin Av. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Cerebral thrombosis | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 wk - 16 years? | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9-25-1941 to 1-20-1958 , that I last saw the deceased alive on 1-20-1958 , and that death occurred at 6:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Hornbaker M.D. 154 West Washington St., Hagerstown, Md. 1-20-58 | | | |
| ACTUAL SIGNATURE John H. Hornbaker | | | |
| PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-23-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman | | ADDRESS *Hagerstown, Maryland | |
| 24a. REC'D BY REGISTRAR JAN 22 '58 | | 24b. REGISTRAR'S SIGNATURE W. F. ... | |

MAINTAIN STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

WILLIAM BOND

BUREAU V. S.

JAN 22 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1243

CERTIFICATE OF DEATH

Reg. Dist. No.

01196

| | | | | | | | |
|---|--|---------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RD6-Hagerstown</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>MARY</u> Middle <u>Eby</u> Last | | | | 4. DATE OF DEATH <u>Jan.</u> Month <u>3</u> Day <u>1958</u> Year | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11/23/1883</u> | |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Wash. Co, Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Abram H. Martin</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Shank</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>David M. Eby</u> Address <u>RD4 Hagerstown, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Failure</u> DUE TO <u>5 years</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u>o. ft.</u> p. m. <u>19</u> Month, Day, Year | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>1-3-58</u> , to <u>1-3-58</u> , that I last saw the deceased alive on <u>1-3-58</u> , and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> ADDRESS <u>Hagerstown Md</u> DATE SIGNED <u>1/4/58</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>[Signature]</u> ADDRESS <u>Hagerstown Md</u> DATE <u>1/4/58</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>1/7/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ruff Cem.</u> | | 22d. LOCATION (City, town, or county) <u>Peartoss, Md.</u> (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Greencastle, Pa</u> | | | | 24a. REC'D BY REGISTRAR <u>JAN 8 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| NAME OF DECEASED <i>John A. Smith</i> | | AGE <i>45</i> | |
| SEX <i>Male</i> | | DATE OF BIRTH <i>1913</i> | |
| RACE <i>White</i> | | EDUCATION <i>High School</i> | |
| OCCUPATION <i>Engineer</i> | | MARITAL STATUS <i>Married</i> | |
| PLACE OF BIRTH <i>Baltimore, Md.</i> | | DATE OF DEATH <i>1958</i> | |
| CAUSE OF DEATH <i>Heart Disease</i> | | MANNER OF DEATH <i>Natural</i> | |
| SIGNATURE OF PHYSICIAN <i>Dr. J. B. Jones</i> | | SIGNATURE OF DEATH REGISTRAR <i>John A. Smith</i> | |
| SIGNATURE OF WITNESS <i>John A. Smith</i> | | SIGNATURE OF WITNESS <i>John A. Smith</i> | |

RECEIVED

BUREAU V. 2

Jan 9 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 01197 | |
|--|--|----------------------------------|--|---|---|---|--|---|--|---|--|
| Dr. Binford 1200 | | | | | | | | | | Reg. Dist. No. 302 | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | | | c. LENGTH OF STAY IN lb <u>41 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>56 Broadway</u> | | | | | d. STREET ADDRESS <u>56 Broadway</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>ELIZA</u> Last <u>EMMERT</u> | | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1958</u> | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 16, 1885</u> | | 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Md. nr. Sharpsburg, Wash. Co.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Peter Remsberg</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Myers</u> | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Leonard R. Emmert-14 Hawthorne Rd.</u> | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hr.</u> <u>unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | |
| 21. I certify that I attended the deceased from <u>8 Sept</u> , 19 <u>52</u> , to <u>20 Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>20 Jan</u> , 19 <u>58</u> , and that death occurred at <u>9 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1135 Potomac Ave., Hagerstown, Md.</u> DATE SIGNED <u>31 Jan '58</u> ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D. PHYSICIAN'S NAME (Type) <u>Richard T. Binford, M.D.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>2-1-58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Sharpsburg, Maryland</u> | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman-Hagerstown, Maryland</u> | | | | | | 24a. REC'D BY REGISTRAR DATE <u>FEB 3 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | | | |

CERTIFICATE OF DEATH



BUREAU V. 1

FEB 3 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1201

CERTIFICATE OF DEATH

01198

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. LENGTH OF STAY IN 1b 20YRS. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | d. STREET ADDRESS 1 337 N. LOCUST ST. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First HARLEY Middle DENNIS Last EVANS | | 4. DATE OF DEATH Month JANUARY Day 17 Year 1958 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/1/1896 |
| 9. AGE (In years last birthday) 61 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY FEED MILL | |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME JENNIE EVANS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 236-28-5196 | |
| 17. INFORMANT MRS. EDNA B. EVANS | | Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension cordis vasculum 22 1/2 yrs (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2 Jan , 19 58 , to 17 Jan , 19 58 , that I last saw the deceased alive on 16 Jan , 19 58 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown Md. DATE SIGNED 1/17/58 ACTUAL SIGNATURE E. Edwards M.D. PHYSICIAN'S NAME (Type) E. Edwards | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 1/19/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | | 22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment ADDRESS Hagerstown, Md. | | 24a. REC'D BY REGISTRAR DATE JAN 21 '58 | |
| 24b. REGISTRAR'S SIGNATURE W. J. Norment | | | |

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

JAN 21 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01199

1244

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg | | c. LENGTH OF STAY IN 1b 60 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 E. Water St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle Grace Last Ferguson | | 4. DATE OF DEATH Month Jan. Day 2 Year 19 58 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 11, 1881 |
| 9. AGE (In years) 76 yrs. | | 10. IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) Charmian, Penna. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME unknown | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mrs. Eloise Smith, Smithsburg, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 wks. 10 yrs. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. 9. Month 19 Day 19 Year 19 p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 11-29- , 19 57 , to 1-2-58 , 19 58 , that I last saw the deceased alive on 1-1- , 19 58 , and that death occurred at 9:15 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Maryland DATE SIGNED ACTUAL SIGNATURE Charles F. Hess M.D. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D. 1-2-58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | 22b. DATE THEREOF 1-4-58 | 22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery | 22d. LOCATION (City, town, or county) (State) Smithsburg, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md. | | 24. REC'D BY REGISTRAR 1958 24b. REGISTRAR'S SIGNATURE W. Minnich | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 224 1-23-58 et

1202

CERTIFICATE OF DEATH

01200

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pennsylvania</u> <u>Washington</u> <u>Franklin</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u> <u>75A-3</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Rest Home 1223 Virginia Ave</u> | | | | d. STREET ADDRESS <u>34 Clayton Ave.</u> <u>1223 Virginia Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL</u> <u>SWOPE</u> <u>FLEAGLE</u> | | | | 4. DATE OF DEATH Month Day Year <u>Jan.</u> <u>14</u> <u>19 58</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 23, 1865</u> | |
| 9. AGE (In years last birthday) yrs. <u>92</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Western Maryland R.R. Clerk and Ticket agent</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Elia Fleagle</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Julian Warrenfeltz</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Address <u>Waynesboro, Pa.</u> <u>Mrs. S.S. Fleagle 34 Clayton Ave.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Basal cell carcinoma of left ear</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from <u>Feb. 24, 1956</u> , to <u>Jan 14, 1958</u> , that I last saw the deceased alive on <u>Jan 9, 1958</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edward W. Ditto</u> , M.D. <u>217 W. Washington Street</u> | | | | DATE SIGNED <u>1/14/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> | | | | ADDRESS <u>Hagerstown, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/17/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Burns Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Waynesboro</u> <u>Penna.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Kalter of Lane</u> | | | | ADDRESS <u>Waynesboro, Pa.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 17 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>W. Beach</u> | | | | | | | |

CERTIFICATE OF DEATH

1908

| | | | | | | | | | | | | | | | |
|------------------------|--|-------------------------|--|------------------------|--|----------------------|--|-------------------------------|--|-----------------------------|--|-------------------------|--|---------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Manner of Death | |
| John Doe | | Male | | 45 | | Jan 1, 1863 | | Maryland | | Baltimore | | Heart Disease | | Natural | |
| Occupation | | Married | | Single | | Widowed | | Divorced | | Date of Death | | Time of Death | | Place of Death | |
| Teacher | | Yes | | No | | No | | No | | Jan 15, 1908 | | 10:30 AM | | Home | |
| Signature of Physician | | Signature of Undertaker | | Signature of Registrar | | Signature of Coroner | | Signature of Medical Examiner | | Signature of Health Officer | | Signature of City Clerk | | Signature of County Clerk | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. 3

JAN 17 1908

RECEIVED

RECEIVED
JAN 17 1908
BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1203

CERTIFICATE OF DEATH

01201

Reg. Dist. No.

| | | | |
|---|---------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN 1b <u>2 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Cordelia</u> Middle <u>J</u> Last <u>Fridinger</u> | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>4</u> Year <u>19 58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 4 1871</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR Months <u>3</u> Days <u>0</u> Hours <u></u> Min. <u></u> | IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>William Rudy</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E Muney</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mr. Williams Fridinger</u> | | Address <u>Williamsport Md RFD #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Sigmoid Colon</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis; Senility</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Jan. 2, 1958</u> , to <u>Jan 4, 1958</u> , that I last saw the deceased alive on <u>Jan 3, 1958</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John A. Moran</u> | | DATE SIGNED <u>1/4/58</u> | |
| PHYSICIAN'S NAME (Type) <u>JOHN A. MORAN</u> | | ADDRESS (Street, city or town, state) <u>215 W. Washington St Hagerstown, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Jan. 6-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 7 '58</u> | |
| ADDRESS <u>Williamsport, Md</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. Leach</u> | |

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. 1

JAN 7 1938

RECEIVED

1204

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 331 Valley Road | | d. STREET ADDRESS 331 Valley Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GILSON E FUSS | | 4. DATE OF DEATH Month Day Year Jan. 23 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 15, 1897 |
| 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Toolmaker | | 10b. KIND OF BUSINESS OR INDUSTRY Machinery | |
| 11. BIRTHPLACE (State or foreign country) Franklin County, Penna. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William C. Fuss | | 14. MOTHER'S MAIDEN NAME Barbara Ann Beaver | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-10-3290 | |
| 17. INFORMANT Mrs. G.E. Fuss | | Address 331 Valley Rd. Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 10 min 1 month | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 15 , 19 57 , to Jan 23 , 19 58 , that I last saw the deceased alive on Jan 3 , 19 58 , and that death occurred at 10 P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Paul Harrison | | DATE SIGNED 1/23/58 | |
| PHYSICIAN'S NAME (Type) PAUL HARRISON | | Hagerstown, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/26/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. | | ADDRESS 1601 Penna. Ave. Hagerstown, Md. | |
| 24a. REC'D BY REGISTRAR Wm. G. Horst | | 24b. REGISTRAR'S SIGNATURE Wm. G. Horst | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--------------------------------------|--|---|--|
| <p>1. NAME OF DECEASED</p> | | <p>2. SEX</p> | |
| <p>3. AGE</p> | | <p>4. DATE OF BIRTH</p> | |
| <p>5. PLACE OF BIRTH</p> | | <p>6. OCCUPATION</p> | |
| <p>7. MARITAL STATUS</p> | | <p>8. CAUSE OF DEATH</p> | |
| <p>9. MEDICAL HISTORY</p> | | <p>10. SIGNATURE OF PHYSICIAN</p> | |
| <p>11. SIGNATURE OF REGISTRAR</p> | | <p>12. DATE OF DEATH</p> | |
| <p>13. PLACE OF DEATH</p> | | <p>14. TIME OF DEATH</p> | |
| <p>15. SIGNATURE OF WITNESS</p> | | <p>16. SIGNATURE OF DECEASED</p> | |
| <p>17. SIGNATURE OF NEXT OF KIN</p> | | <p>18. SIGNATURE OF BURIAL OFFICIAL</p> | |
| <p>19. SIGNATURE OF FUNERAL HOME</p> | | <p>20. SIGNATURE OF CHURCH</p> | |
| <p>21. SIGNATURE OF CEMETERY</p> | | <p>22. SIGNATURE OF INTERVIEWER</p> | |
| <p>23. SIGNATURE OF INTERVIEWER</p> | | <p>24. SIGNATURE OF INTERVIEWER</p> | |
| <p>25. SIGNATURE OF INTERVIEWER</p> | | <p>26. SIGNATURE OF INTERVIEWER</p> | |
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| <p>97. SIGNATURE OF INTERVIEWER</p> | | <p>98. SIGNATURE OF INTERVIEWER</p> | |
| <p>99. SIGNATURE OF INTERVIEWER</p> | | <p>100. SIGNATURE OF INTERVIEWER</p> | |

BUREAU Y. S.

JAN 28 1958

RECEIVED

1205

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | | c. LENGTH OF STAY IN 1b 2 YEARS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARTIN MANOR NURSING HOME | | | | /d. STREET ADDRESS RURAL CLEAR SPRING | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM M. GEHR | | | | 4. DATE OF DEATH Month Day Year 1 2 19 58 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN 2, 1874 | 9. AGE (In years last birthday) 84 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY OWN FARM | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOSEPH GEHR | | | | 14. MOTHER'S MAIDEN NAME ANNA MASON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address W.R. GEHR CLEAR SPRING RT 1 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sclerotic Heart Disease 4 yrs. 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of Bladder 4 yrs. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Dec 9, 1957 to Jan 2, 1958 , that I last saw the deceased alive on Jan 1, 1958 , and that death occurred at 10:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED David R. Brewer M.D. 1/2/58 | | | | | | | |
| ACTUAL SIGNATURE David R. Brewer | | | | PHYSICIAN'S NAME (Type) David R. Brewer Clear Spring Md. | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF JAN 6, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY REST HAVEN | | 22d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark | | | | ADDRESS CLEAR SPRING MD. | | 24a. REC'D BY REGISTRAR DATE JAN 6 1958 | |
| | | | | 24b. REGISTRAR'S SIGNATURE H. M. M. M. M. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1958 6 4N

[illegible]

1206

CERTIFICATE OF DEATH

Reg. Dist. No. 01204

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN Md. STATE Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN FRANKLIN Gift</u> | | 4. DATE OF DEATH Month Day Year <u>JAN. 11 1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 13, 1888</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSTRUCTION WORKER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | 11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> | | 13. FATHER'S NAME <u>DAVID Gift</u> | |
| 14. MOTHER'S MAIDEN NAME <u>REBECCA REED</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>212-03-1060A</u> | | 17. INFORMANT Address <u>MRS. VIVIAN TURNER HAGERSTOWN, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONFLUENT LOBULAR PNEUMONIA</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>TRACHEO-ESOPHAGEAL FISTULA</u> DUE TO (c) <u>CARCINOMA of ESOPHAGUS</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>6 MONTHS</u> <u>2 YEARS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>NOV. 20, 1957</u> , to <u>JAN. 11, 1958</u> , that I last saw the deceased alive on <u>JAN. 11, 1958</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Evaristo R. Lardizabal</u> M.D. | | WESTERN Md. STATE Hospital | |
| PHYSICIAN'S NAME (Type) <u>EVARISTO R LARDIZABAL</u> | | <u>HAGERSTOWN Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, county) (State) |
| <u>Burial</u> | <u>1/14/58</u> | <u>Rose Hill Cem. Hagerstown, Md.</u> | <u>Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Norman</u> | | 24a. REC'D BY REGISTRAR <u>DATE 1 4 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>W. J. Norman</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------|--|---------------------------------|--|-------------------------------|--|
| NAME OF DECEASED _____ | | SEX _____ | | AGE _____ | |
| PLACE OF BIRTH _____ | | DATE OF BIRTH _____ | | TIME OF BIRTH _____ | |
| OCCUPATION _____ | | CAUSE OF DEATH _____ | | MANNER OF DEATH _____ | |
| PLACE OF DEATH _____ | | DATE OF DEATH _____ | | TIME OF DEATH _____ | |
| SIGNATURE OF PHYSICIAN _____ | | SIGNATURE OF REGISTRAR _____ | | SIGNATURE OF WITNESS _____ | |

BUREAU V. S.

JAN 14 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1207

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Nursing Home</u> | | d. STREET ADDRESS <u>Main St</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>ALBERT</u> Last <u>GLESNER</u> | | 4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 7 1865</u> |
| 9. AGE (In years last birthday) <u>92</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Jacob F. Glesner</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret McLaughlin</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs Blanche Conner Maugansville Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 yrs</u> DUE TO <u>senility</u> (c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>6-1-1971</u> to <u>1-24-1958</u> , that I last saw the deceased alive on <u>1-22-58</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr. W. D. Smith</u> | | DATE SIGNED <u>1/29/58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1/27/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash. Co Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u> | | 24a. REC'D BY REGISTRAR <u>JAN 28 58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | DATE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE HERE THE NAME OF THE DECEASED

SEX

AGE

PLACE HERE THE ADDRESS OF THE DECEASED

CITY

STATE

COUNTY

PLACE HERE THE NAME OF THE PHYSICIAN

SIGNATURE

DATE

PLACE HERE THE NAME OF THE CORONER

SIGNATURE

DATE

PLACE HERE THE NAME OF THE MINISTER

SIGNATURE

DATE

PLACE HERE THE NAME OF THE CLERGYMAN

SIGNATURE

DATE

PLACE HERE THE NAME OF THE MINISTER

SIGNATURE

DATE

PLACE HERE THE NAME OF THE CLERGYMAN

SIGNATURE

DATE

PLACE HERE THE NAME OF THE MINISTER

SIGNATURE

DATE

PLACE HERE THE NAME OF THE CLERGYMAN

SIGNATURE

DATE

PLACE HERE THE NAME OF THE MINISTER

SIGNATURE

DATE

PLACE HERE THE NAME OF THE CLERGYMAN

SIGNATURE

DATE

DAVID BOMIE

BUREAU V. 1

JAN 28 1958

RECEIVED

1208 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH o. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 5 YEARS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1016 MULBERRY AVE. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 1016 MULBERRY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WILLIAM HAROLD GRAY First Middle Last | | 4. DATE OF DEATH JANUARY 13 1958 Month Day Year | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH MAY 28 1897 9. AGE (In years lost birthday) 60 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RADIO ANNOUNCER STATION W.J.E.J. | | 10b. KIND OF BUSINESS OR INDUSTRY ROANOKE VIRGINIA | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME STOKELEY E. GRAY | | 14. MOTHER'S MAIDEN NAME LOU ANN SPARKS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT STATION W.J.E.J. HAGERSTOWN MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 10 min. 2 yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept 10 , 19 57 , to Nov 20 , 19 57 , that I last saw the deceased alive on Nov 20 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac ST DATE SIGNED 1/14/58 | | | |
| ACTUAL SIGNATURE Paul Harrison | | M.D. Hagerstown, Maryland | |
| PHYSICIAN'S NAME (Type) PAUL HARRISON MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 16 1958 | 22c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEMETERY | 22d. LOCATION (City, town, or county) (State) ROANOKE VIRGINIA |
| 23. FUNERAL DIRECTOR'S SIGNATURE Paul Jewel Dore | | 24a. REC'D BY REGISTRAR Booushu md DATE JAN 16 58 | |
| | | 24b. REGISTRAR'S SIGNATURE W. H. H. H. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 16 1938

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Md.
JAN 16 1938

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01207

1245

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>126 North Conococheague Street</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Walter</u> Last <u>Harrison</u> | | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 11 1886</u> | |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR Months <u>3</u> Days <u>12</u> | | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>BRICK YARD</u> | | 11. BIRTHPLACE (State or foreign country) <u>St. Thomas Pa.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>William Harrison</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Gift</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>220-09-9240</u> | | 17. INFORMANT <u>Mrs. Harry Banzhoff</u> | |
| | | | | Address: <u>126 N. Conococheague Williamsport Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immediate</u> DUE TO (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) <u>Williamsport</u> | | | | 20g. (County) <u>Maryland</u> | | 20h. (State) <u>Md</u> | |
| 21. I certify that I attended the deceased from <u>1/22/58</u> , 19 <u>58</u> , to <u>1/23/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/23/58</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Robert Young</u> | | | | DATE SIGNED <u>1/24/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>William Harrison</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 26-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport Md</u> | | | | 24a. REC'D BY REGISTRAR <u>Jan 27 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur</u> | |

CERTIFICATE OF DEATH

FILE NO. 111

General Thomas A. ...

1/23/28
1/23/28
1/23/28

BUREAU V. T.

JAN 27 1928

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 224 1-24-58 et

1209

CERTIFICATE OF DEATH

01208

Reg. Dist. No. 302

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | | c. LENGTH OF STAY IN 1b <u>14</u> days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>ELSA</u> Middle <u>EBERLY</u> Last <u>HASSETT</u> | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>18</u> Year <u>19 58</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>September 14, 1899</u> | |
| 9. AGE (In years last birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. | | IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | |
| 13. FATHER'S NAME <u>Henry Rothrock</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Eberly</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>William R. Moore III Hagerstown, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Metastases</u> <u>195.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant tumor of thymus</u> DUE TO (c) <u>1 yr. +</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 wks.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u>19</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> a. m. p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) <u>Hagerstown, Maryland</u> | | | | 20g. (State) <u>Md.</u> | | | |
| 21. I certify that I attended the deceased from <u>Dec 10</u> , 19 <u>56</u> , to <u>Jan 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 11</u> , 19 <u>58</u> , and that death occurred at <u>3:40 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>214 N. Potomac St.</u> DATE SIGNED <u>Lloyd A. Hoffman</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u> M.D. <u>214 N. Potomac St.</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u> <u>Hagerstown, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/20/1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Buzar</u> | | | | ADDRESS <u>Hagerstown, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 22 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u> | | | |

CERTIFICATE OF DEATH

RECEIVED
JAN 22 1938
BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01209

Reg. Dist. No.

FOR STATE
HEALTH-DEPT.

| | | | |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN TB 50 Yrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 301 1/2 N. Jonathan Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Odiaus (No) Jackson | | 4. DATE OF DEATH Month Jan. Day 14 Year 58 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 12, 1881 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months 7 Days 6 | 11. IF UNDER 24 HRS. Hours 19 Min. 58 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY Church | |
| 11. BIRTHPLACE (State or foreign country) Hillsboro Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknow | | 14. MOTHER'S MAIDEN NAME Unknow | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. nene | |
| 17. INFORMANT Mrs. Cernelia Eubanks 647 Forest Dr. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic myocardial heart disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with myocardial failure grade iv DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) (County) (State) - - - | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE S. Robert Wells | | DATE SIGNED | |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 19, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown Wash Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md | | 24a. REC'D BY REGISTRAR DATE JAN 16 '58 | |
| 24b. REGISTRAR'S SIGNATURE W. H. H. H. | | | |

RECEIVED

JAN 16 1953

BUREAU V. S.

FOR STATE
HEALTH DEPT.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
121 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01210

Reg. Dist. No.

| | | | |
|--|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 135 Fairground Ave. | | d. STREET ADDRESS 135 Fairground Ave. | |
| 3. NAME OF DECEASED (Type or print) First MINNIE Middle F Last JAMESON | | 4. DATE OF DEATH Month Jan. Day 14 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 24, 1889 |
| 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | |
| 11. BIRTHPLACE (State or foreign country) Chestnut Grove, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Holmes | | 14. MOTHER'S MAIDEN NAME Elizabeth Mobley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-16-0807 | |
| 17. INFORMANT Mrs. Lola V. Fales | | Address R #1 Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic myocardial heart disease with myocardial failure grade iv Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) - (County) - (State) - | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 1-20-58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1 | | 22b. DATE THEREOF 1/21/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md. | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE | |

Wm A. Stont U.S.A.

BUREAU V. S.

AN 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1246

CERTIFICATE OF DEATH

01211

Reg. Dist. No.

| | | | | | | | |
|---|--|----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R. 2</u> | | | | c. LENGTH OF STAY IN 1b <u>3 1/2 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Nursing Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Richard Venney</u> | | | | 4. DATE OF DEATH <u>Jan 10 1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 11, 1881</u> | |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | 10. IF UNDER 1 YEAR | | 11. IF UNDER 24 HRS. | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Munson, Penna.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>John Venney</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Ann Carter</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT <u>Mrs. Maurice Berringer</u> | | | | Address <u>1135 Stanley Ave. Chambersburg, Pa.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>July 18, 1954</u> to <u>Jan 10, 1958</u> , that I last saw the deceased alive on <u>Jan 9, 1958</u> , and that death occurred at <u>9:00</u> A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>David R. Brewer</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>1/10/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>David R. Brewer</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/13/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Wings Pine</u> | | 22d. LOCATION (City, town, or county) (State) <u>Allport, Clar. Co. Penna.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick W. Krauss</u> ADDRESS <u>Hagerstown Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>Jan 15 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alfred</u> | |

BUREAU V. S.

JAN 15 1958

RECEIVED

1247

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

CERTIFICATE OF DEATH

| | | | |
|---------------------------------------|--|---------------------------------------|--|
| PLACE OF DEATH Baltimore | | COUNTY Baltimore | |
| NAME OF DECEASED [Illegible] | | SEX Male | |
| DATE OF DEATH [Illegible] | | TIME OF DEATH [Illegible] | |
| PLACE OF BIRTH [Illegible] | | AGE [Illegible] | |
| OCCUPATION [Illegible] | | CAUSE OF DEATH [Illegible] | |
| SIGNATURE OF PHYSICIAN [Illegible] | | SIGNATURE OF REGISTRAR [Illegible] | |
| SIGNATURE OF WITNESS [Illegible] | | SIGNATURE OF DECEASED [Illegible] | |

BUREAU V. 2

JAN 15 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01213

1212

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN 1b <u>60 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1115 Mt. Etna Road</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>BERNICE</u> Middle <u>OSWALD</u> Last <u>KINDLE</u> | | 4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/30/1863</u> |
| 9. AGE (In years last birthday) <u>94</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (State or foreign country) <u>Wolfville, Md.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>John Wesley Hoover</u> | |
| 14. MOTHER'S MAIDEN NAME <u>SARAH M. OSWALD</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u> | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs. Anna Lynch - Hagerstown, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u> | 20d. KIND OF INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> |
| 21. I certify that I attended the deceased from <u>1/3/58</u> , 19 <u>58</u> , to <u>1/3/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/3/58</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D. | | ADDRESS (Street, city or town, state) <u>Williamstown, Md.</u> DATE SIGNED <u>1/4/58</u> | |
| PHYSICIAN'S NAME (Type) <u>RALPH F. YOUNG</u> | | 22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> | |
| 22b. DATE THEREOF <u>1/5/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Funkstown</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Funkstown, Md.</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Winnick</u> ADDRESS <u>Greenleaf, Pa.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>JAN 8 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. Beach</u> | |

RECEIVED

14N 8 1958

BUREAU V. 2

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

1213

CERTIFICATE OF DEATH

Reg. Dist. No.

01214

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN b 2 weeks | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Chewsville | | d. STREET ADDRESS 1 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle Robert Last Kinna | | 4. DATE OF DEATH Month Jan. Day 21, Year 1958 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 9, 1909 |
| 9. AGE (In years last birthday) 48 | | IF UNDER 1 YEAR Months 48 Days 48 Hours 48 Min. 48 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher | | 10b. KIND OF BUSINESS OR INDUSTRY public school | |
| 11. BIRTHPLACE (State or foreign country) Chewsville, Md. | | 12. CITIZEN OF WHAT COUNTRY? Chewsville, Md. | |
| 13. FATHER'S NAME Charles Kinna | | 14. MOTHER'S MAIDEN NAME Anne Bachtell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Charlotte Kinna, Chewsville, Md. | | Address Charlotte Kinna, Chewsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Neuroinfection DUE TO 445x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant Hypertension DUE TO 2 wks. (c) Benign Essential Hypertension DUE TO 15 years. | | INTERVAL BETWEEN ONSET AND DEATH 10 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) — | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. — p. m. — 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jan 21, 1958 | | 20f. (City or town) (County) (State) Chewsville, Md. | |
| 21. I certify that I attended the deceased from Jan 21, 1958 , to Jan 21, 1958 , that I last saw the deceased alive on Jan 21, 1958 , and that death occurred at 9:45 PM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND | |
| ACTUAL SIGNATURE J. D. Wilson | | DATE SIGNED 1/21/58 | |
| PHYSICIAN'S NAME (Type) J. D. WILSON, M.D. | | M.D. 135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 1-24-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery | | 22d. LOCATION (City, town, or county) (State) Smithsburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md. | | 24a. REC'D BY REGISTRAR Jan 27 1958 | |
| 24b. REGISTRAR'S SIGNATURE Chewsville, Md. | | 24c. REGISTRAR'S SIGNATURE Chewsville, Md. | |

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1214

CERTIFICATE OF DEATH

01215

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First SYLVIAN Middle JAMES Last Twin | | | | 4. DATE OF DEATH Month Jan Day 11 Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/10/58 | | 9. AGE (In years last birthday) yrs. 16 | IF UNDER 1 YEAR Months 16 Days 41 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Hagerstown, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Harold E. Klink | | | | 14. MOTHER'S MAIDEN NAME Virginia L. Tyler | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mr. Harold E. Klink Address 941 Main Ave. Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Diabetes - Severe Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO (c) ----- | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 16 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ----- | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 1/10/58 , to 1/11/58 , that I last saw the deceased alive on 1/10/58 , and that death occurred at 3 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 302 N. Potomac St. Hagerstown, Md. DATE SIGNED 1/13/58 | | | | | | | |
| ACTUAL SIGNATURE A.M. Bacon M.D. ----- | | | | | | | |
| PHYSICIAN'S NAME (Type) A.M. Bacon M.D. 302 N. Potomac St. Hagerstown, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/13/58 | | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel | | | | ADDRESS 1601 Penna. Ave. Hagerstown, Md. | | 24a. REC'D BY REGISTRAR DATE 1 5 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Re. Leach | | | |

2281289XV2 Wm. A. Hank & Sons.

NEW YORK STATE DEPARTMENT OF HEALTH—BALTIMORE 10

BUREAU V. S.

JAN 16 1953

RECEIVED

1248

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|--|---------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Loudoun</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> | | | | c. LENGTH OF STAY IN 1b <u>6 mos. 12 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u> | | | | d. STREET ADDRESS <u>Leesburg</u> <u>83X 3</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Allene</u> Middle <u>Lacy</u> Last <u>Lacy</u> | | | | 4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 15, 1881</u> | 9. AGE (In years last birthday) <u>76 1/2</u> yrs. | IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>3</u> Min. | IF UNDER 24 HRS. Hours <u>3</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Kentucky</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Dr. H Allen Tupper</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Molly Pender</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs. Mollie Winn, Fort Ritchie, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Encephalopathy</u> DUE TO (c) <u>2 yrs.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>6/24</u> 19 <u>57</u> , to <u>2 Jan</u> 19 <u>58</u> , that I last saw the deceased alive on <u>2 Jan</u> 19 <u>58</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Paul Haak</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>2800 Gatehome Street</u> DATE SIGNED <u>2 Jan 58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>PAUL HAAK, M.D.</u> | | | | <u>Williamsport, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>Jan. 3, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>J. William Lee Crematory</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Lef</u> ADDRESS <u>Williamsport, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>Jan 6 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>U. Mednick</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

Page One of Two

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The form is divided into several horizontal sections with labels for each field.

BUREAU V. 2

JAN 6 1938

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1215

CERTIFICATE OF DEATH

Reg. Dist. No. 01217

| | | | |
|---|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u> | | d. STREET ADDRESS <u>42 N. Carl Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>Williams</u> Middle <u>Laubs</u> Last | | 4. DATE OF DEATH <u>Jan.</u> Month <u>20</u> Day <u>1958</u> Year | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/24/1880</u> |
| 9. AGE (In years lost birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroader</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Lineman</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Greencastle</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Laubs</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Byers</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>172-91-9401</u> | |
| 17. INFORMANT <u>Gerry Laubs</u> Address <u>Greencastle, Pa.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>332 x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio-Sclerosis</u> DUE TO (c) <u>20 years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hicatus</u> <u>Hernia</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>20 Jan</u> , 19 <u>58</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>P. F. Webster</u> M.D. <u>Greencastle Pa</u> | | ADDRESS (Street, city or town, state) <u>Greencastle Pa</u> DATE SIGNED <u>Jan 21/58</u> | |
| PHYSICIAN'S NAME (Type) <u>P. F. WEBSTER</u> | | <u>GREENCASTLE PA</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u> | | 22b. DATE THEREOF <u>1/25/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich</u> ADDRESS <u>Greencastle, Pa.</u> | | 24a. REC'D BY REGISTRAR <u>JAN 23 '58</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

CERTIFICATE OF DEATH

1958

| | | | | | | | |
|------------------------|--|------------------------|--|-----------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | |
| PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | DATE OF MARRIAGE | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | |
| CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE NO. | | REGISTERED | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |

BUREAU V. 1

JAN 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1249

CERTIFICATE OF DEATH

01218

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitorium | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 632 Guilford Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Frederick Middle William Last Lillard | | | | 4. DATE OF DEATH Month January Day 7 Year 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 5, 1899 | |
| 9. AGE (In years last birthday) 58 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Manager | | 10b. KIND OF BUSINESS OR INDUSTRY Bus Co. | | 11. BIRTHPLACE (State or foreign country) Page Co. Va. | |
| 13. FATHER'S NAME William A. Lillard | | | | 14. MOTHER'S MAIDEN NAME Elizabeth F. Strickler | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 219-14-9569 | | 17. INFORMANT Address Mrs Virginia Lillard Hagerstown Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumoniz - broncho. 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malignant hypertensive vascular disease - 10 yrs. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 6, 1954 to Jan 6, 1958 , that I last saw the deceased alive on Jan 6, 1958 , and that death occurred at 12:30 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Claydon A. Hoffman | | ADDRESS (Street, city or town, state) 214 N. Potomac St Hag. Md. DATE SIGNED 1/9/58 | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Lloyd A. Hoffman | | Hagerstown Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-9-58 | | 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son | | | | ADDRESS Hagerstown Md. | | 24a. REC'D BY REGISTRAR JAN 13 58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE [Signature] | | | |

CERTIFICATE OF DEATH

| | | | |
|---|--|------------------------------------|--|
| NAME OF DECEASED William A. Hillard | | LOCALITY Baltimore | |
| DATE OF DEATH January 18, 1938 | | AGE 3 years | |
| PLACE OF DEATH Home | | MANNER OF DEATH Natural | |
| RESIDENCE 1100 N. Howard St., Baltimore, Md. | | OCCUPATION None | |
| EDUCATION None | | RELIGION None | |
| CAUSE OF DEATH Sudden | | IMMEDIATE CAUSE None | |
| DISEASE OR INJURY None | | TREATMENT None | |
| SIGNATURE OF PHYSICIAN None | | SIGNATURE OF REGISTRAR None | |
| DATE OF REGISTRATION January 18, 1938 | | PLACE OF REGISTRATION Baltimore | |

BUREAU A. 2

JAN 18 1938

Handwritten notes and stamps at the bottom left corner.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1216

CERTIFICATE OF DEATH

Reg. Dist. No. 502

01219

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN 1b <u>3 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Irene</u> Last <u>Lushbaugh</u> | | 4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>19 58</u> | |
| 5. SEX <u>Fe Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 17 1903</u> |
| 9. AGE (In years last birthday) <u>54</u> yrs. | | IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u> Hours <u></u> Min. <u></u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Top Stitcher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Waynesboro shoe</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>James Jenkins</u> | | 14. MOTHER'S MAIDEN NAME <u>Carrie Slick</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>173-03-3047</u> | |
| 17. INFORMANT <u>Carl E Lushbaugh</u> | | Address <u>Hagerstown Route 5</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of cervix with general</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>pelvic metastasis</u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 Mos.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardio Vascular Disease</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Dec 25, 1957</u> , to <u>Jan 23, 1958</u> , that I last saw the deceased alive on <u>Jan 22, 1958</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 W. Washington St. Hagerstown, Md.</u> DATE SIGNED <u>1/23/58</u> ACTUAL SIGNATURE <u>Edward W. Ditto</u> PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, M.D. Hagerstown, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>January 25 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose hill</u> | 22d. LOCATION (City, town or county) (State) <u>Hagerstown, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> | | ADDRESS <u>Hagerstown, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 28 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Deborah</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 28 1958

BUREAU V. B.

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

TO BE RETAINED BY HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1250

CERTIFICATE OF DEATH

Reg. Dist. No. 01220

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY Berkeley | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport | | c. LENGTH OF STAY IN 1b 7Mos. 4 Wks. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 85x-3 d. STREET ADDRESS 377 Boyd Ave. | |
| 3. NAME OF DECEASED (Type or print) Bertha First Lena Middle Miles Last | | 4. DATE OF DEATH Month January Day 25 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 28, 1882 |
| 9. AGE (In years last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 11 Days 28 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Martinsburg W.Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Imbach | | 14. MOTHER'S MAIDEN NAME Julia Lampas | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Bruce F. Miles | | Address Martinsburg W.Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Generalized DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 1/2 H. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March, 1955 to Jan 25, 1958 , that I last saw the deceased alive on Nov , 19 57 , and that death occurred at 8:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12450 Balmain St Martinsburg W.Va DATE SIGNED 1/27/58 | | | |
| ACTUAL SIGNATURE W R M Cune M.D. | | PHYSICIAN'S NAME (Type) W R M Cune MARTINSBURG W.Va | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/28/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery | | 22d. LOCATION (City, town, or county) (State) Martinsburg W.Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown | | ADDRESS Martinsburg W.Va. | |
| 24a. REC'D BY REGISTRAR JAN 30 '58 | | 24b. REGISTRAR'S SIGNATURE Overman | |

CERTIFICATE OF DEATH

STATE OF NEW YORK - BUREAU OF HEALTH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister

DATE OF BIRTH

PLACE OF BIRTH

RELIGION

EDUCATION

Marital Status

Occupation

Income

Usual Residence

Place of Burial

Signature of Registrar

Signature of Coroner

BUREAU V. B.

JAN 30 1958

RECEIVED

Signature of Registrar

Signature of Coroner

Signature of Minister

Signature of Registrar

Signature of Coroner

CERTIFICATE OF DEATH

Reg. Dist. No.

1251

| | | | | | | | |
|---|-------------------------------|--|---------------------------------------|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANMAR | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VIENNA 85X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAHRNEY KEEDY MEMORIAL HOME | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ANNA Middle L. Last MILLER | | | | 4. DATE OF DEATH Month JANUARY Day 8 Year 1958 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUGUST 2 1869 | | 9. AGE (In years last birthday) 88 yrs. | | IF UNDER 1 YEAR: Months 8 Days 19 Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) SANGERVILLE VIRGINIA | |
| 13. FATHER'S NAME MARTIN GABER | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH SAYER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO [If yes, give war or dates of service] | | | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT RECORDS FAHRNEY KEEDY MEMORIAL HOME Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Generalized arteriosclerosis DUE TO Coronary Thromboses Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1042 DUE TO (c) 15 minutes | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from Jan 8 , 19 58 to Jan 8 , 19 58 , that I last saw the deceased alive on Jan 8 , 19 58 , and that death occurred at 5:10 P. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE G. W. Helman | | | | ADDRESS (Street, city or town, state) Bonabro Bnd. | | | |
| PHYSICIAN'S NAME (Type) G. W. Helman | | | | DATE SIGNED 1/9/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF JAN. 11 1958 | | 22c. NAME OF CEMETERY OR CREMATORY CHURCH OF THE BRETHREN CEMETERY OAKTON VIRGINIA | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Money & King Funeral Home Vienna Virginia | | | | 24a. REC'D BY REGISTRAR DATE JAN 10 '58 | | 24b. REGISTRAR'S SIGNATURE Reed Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form D-1-10

| | | | | | |
|--|--|---|--|---|--|
| 1. NAME OF DECEASED JOHN J. BROWN | | 2. SEX MALE | | 3. AGE 45 | |
| 4. DATE OF DEATH 1958 JAN 10 | | 5. TIME OF DEATH 10:00 AM | | 6. PLACE OF DEATH HOME | |
| 7. CAUSE OF DEATH HEART DISEASE | | 8. MANNER OF DEATH NATURAL | | 9. SIGNATURE OF PHYSICIAN J. J. BROWN | |
| 10. SIGNATURE OF REGISTRAR J. J. BROWN | | 11. SIGNATURE OF WITNESS J. J. BROWN | | 12. SIGNATURE OF WITNESS J. J. BROWN | |
| 13. SIGNATURE OF WITNESS J. J. BROWN | | 14. SIGNATURE OF WITNESS J. J. BROWN | | 15. SIGNATURE OF WITNESS J. J. BROWN | |
| 16. SIGNATURE OF WITNESS J. J. BROWN | | 17. SIGNATURE OF WITNESS J. J. BROWN | | 18. SIGNATURE OF WITNESS J. J. BROWN | |
| 19. SIGNATURE OF WITNESS J. J. BROWN | | 20. SIGNATURE OF WITNESS J. J. BROWN | | 21. SIGNATURE OF WITNESS J. J. BROWN | |
| 22. SIGNATURE OF WITNESS J. J. BROWN | | 23. SIGNATURE OF WITNESS J. J. BROWN | | 24. SIGNATURE OF WITNESS J. J. BROWN | |
| 25. SIGNATURE OF WITNESS J. J. BROWN | | 26. SIGNATURE OF WITNESS J. J. BROWN | | 27. SIGNATURE OF WITNESS J. J. BROWN | |
| 28. SIGNATURE OF WITNESS J. J. BROWN | | 29. SIGNATURE OF WITNESS J. J. BROWN | | 30. SIGNATURE OF WITNESS J. J. BROWN | |
| 31. SIGNATURE OF WITNESS J. J. BROWN | | 32. SIGNATURE OF WITNESS J. J. BROWN | | 33. SIGNATURE OF WITNESS J. J. BROWN | |
| 34. SIGNATURE OF WITNESS J. J. BROWN | | 35. SIGNATURE OF WITNESS J. J. BROWN | | 36. SIGNATURE OF WITNESS J. J. BROWN | |
| 37. SIGNATURE OF WITNESS J. J. BROWN | | 38. SIGNATURE OF WITNESS J. J. BROWN | | 39. SIGNATURE OF WITNESS J. J. BROWN | |
| 40. SIGNATURE OF WITNESS J. J. BROWN | | 41. SIGNATURE OF WITNESS J. J. BROWN | | 42. SIGNATURE OF WITNESS J. J. BROWN | |
| 43. SIGNATURE OF WITNESS J. J. BROWN | | 44. SIGNATURE OF WITNESS J. J. BROWN | | 45. SIGNATURE OF WITNESS J. J. BROWN | |
| 46. SIGNATURE OF WITNESS J. J. BROWN | | 47. SIGNATURE OF WITNESS J. J. BROWN | | 48. SIGNATURE OF WITNESS J. J. BROWN | |
| 49. SIGNATURE OF WITNESS J. J. BROWN | | 50. SIGNATURE OF WITNESS J. J. BROWN | | 51. SIGNATURE OF WITNESS J. J. BROWN | |
| 52. SIGNATURE OF WITNESS J. J. BROWN | | 53. SIGNATURE OF WITNESS J. J. BROWN | | 54. SIGNATURE OF WITNESS J. J. BROWN | |
| 55. SIGNATURE OF WITNESS J. J. BROWN | | 56. SIGNATURE OF WITNESS J. J. BROWN | | 57. SIGNATURE OF WITNESS J. J. BROWN | |
| 58. SIGNATURE OF WITNESS J. J. BROWN | | 59. SIGNATURE OF WITNESS J. J. BROWN | | 60. SIGNATURE OF WITNESS J. J. BROWN | |
| 61. SIGNATURE OF WITNESS J. J. BROWN | | 62. SIGNATURE OF WITNESS J. J. BROWN | | 63. SIGNATURE OF WITNESS J. J. BROWN | |
| 64. SIGNATURE OF WITNESS J. J. BROWN | | 65. SIGNATURE OF WITNESS J. J. BROWN | | 66. SIGNATURE OF WITNESS J. J. BROWN | |
| 67. SIGNATURE OF WITNESS J. J. BROWN | | 68. SIGNATURE OF WITNESS J. J. BROWN | | 69. SIGNATURE OF WITNESS J. J. BROWN | |
| 70. SIGNATURE OF WITNESS J. J. BROWN | | 71. SIGNATURE OF WITNESS J. J. BROWN | | 72. SIGNATURE OF WITNESS J. J. BROWN | |
| 73. SIGNATURE OF WITNESS J. J. BROWN | | 74. SIGNATURE OF WITNESS J. J. BROWN | | 75. SIGNATURE OF WITNESS J. J. BROWN | |
| 76. SIGNATURE OF WITNESS J. J. BROWN | | 77. SIGNATURE OF WITNESS J. J. BROWN | | 78. SIGNATURE OF WITNESS J. J. BROWN | |
| 79. SIGNATURE OF WITNESS J. J. BROWN | | 80. SIGNATURE OF WITNESS J. J. BROWN | | 81. SIGNATURE OF WITNESS J. J. BROWN | |
| 82. SIGNATURE OF WITNESS J. J. BROWN | | 83. SIGNATURE OF WITNESS J. J. BROWN | | 84. SIGNATURE OF WITNESS J. J. BROWN | |
| 85. SIGNATURE OF WITNESS J. J. BROWN | | 86. SIGNATURE OF WITNESS J. J. BROWN | | 87. SIGNATURE OF WITNESS J. J. BROWN | |
| 88. SIGNATURE OF WITNESS J. J. BROWN | | 89. SIGNATURE OF WITNESS J. J. BROWN | | 90. SIGNATURE OF WITNESS J. J. BROWN | |
| 91. SIGNATURE OF WITNESS J. J. BROWN | | 92. SIGNATURE OF WITNESS J. J. BROWN | | 93. SIGNATURE OF WITNESS J. J. BROWN | |
| 94. SIGNATURE OF WITNESS J. J. BROWN | | 95. SIGNATURE OF WITNESS J. J. BROWN | | 96. SIGNATURE OF WITNESS J. J. BROWN | |
| 97. SIGNATURE OF WITNESS J. J. BROWN | | 98. SIGNATURE OF WITNESS J. J. BROWN | | 99. SIGNATURE OF WITNESS J. J. BROWN | |
| 100. SIGNATURE OF WITNESS J. J. BROWN | | 101. SIGNATURE OF WITNESS J. J. BROWN | | 102. SIGNATURE OF WITNESS J. J. BROWN | |

BUREAU V. S.

JAN 10 1958

RECEIVED

1252

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Big Pool Md. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Big Pool Md. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home | | | | d. STREET ADDRESS Rural Big Pool Md. | | | |
| 3. NAME OF DECEASED (Type or print) First Thomas Middle Albert Last Mills | | | | 4. DATE OF DEATH Month 1 Day 3 Year 58 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9.15.1877 | | 9. AGE (In years last birthday) 80 yrs. | IF UNDER 1 YEAR Months 2 Days 18 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Air Craft | | | | 10b. KIND OF BUSINESS OR INDUSTRY Washington County Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James M Mills | | | | 14. MOTHER'S MAIDEN NAME Mary Long | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N | | 16. SOCIAL SECURITY NO. 705-10-5916 | | 17. INFORMANT Mrs Anna Mills Big Pool Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) 2 hrs INTERVAL BETWEEN ONSET AND DEATH Yrs | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Jan 3 , 19 58 , to Jan 3 , 19 58 , that I last saw the deceased alive on Jan 3 , 19 58 , and that death occurred at M , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE H. H. Schaffer M.D. | | | | ADDRESS (Street, city or town, state) Hancock, Md. | | | |
| PHYSICIAN'S NAME (Type) Hancock, Md. | | | | DATE SIGNED 1/5/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1.6.58 | | 22c. NAME OF CEMETERY OR CREMATORIUM Park Head | | 22d. LOCATION (City, town, or county) (State) Park Head Washington Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Moore Hancock Md | | | | ADDRESS Hancock Md | | 24a. REC'D BY REGISTRAR DATE JAN 9 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Overhill | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. R.

Nov 9 1958

RECEIVED

1217

CERTIFICATE OF DEATH

01223

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 2 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital | | e. STREET ADDRESS RFD #1 | |
| 3. NAME OF DECEASED (Type or print) First Lui Middle Mioni Last Mioni | | 4. DATE OF DEATH Month Jan. Day 12, Year 1958 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 3, 1880 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY cement plant | |
| 11. BIRTHPLACE (State or foreign country) Treppo Grande, Italy | | 12. CITIZEN OF WHAT COUNTRY? Italy | |
| 13. FATHER'S NAME Domenico Mioni | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Wash. Co. Hospital, Hagerstown, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Coronary atherosclerosis (c) Generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 3 days unknown unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 27, 1956 , to Jan 12, 1958 , that I last saw the deceased alive on Jan 12, 1958 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L. L. Packer, Jr. | | ADDRESS (Street, city or town, state) 145 W. Washington St. Hagerstown, Md. | |
| PHYSICIAN'S NAME (Type) L.L. Packer, Jr. M.D. | | DATE SIGNED 1/13/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 1-14-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md. | | ADDRESS | |
| 24a. RECEIVED BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

JAN 16 1953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1253

CERTIFICATE OF DEATH

01224

Reg. Dist. No.

| | | | | | |
|--|-------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 Fairview Drive | | | e. STREET ADDRESS 108 Fairview Drive | | |
| 3. NAME OF DECEASED (Type or print) First Remus Middle Lee Last Moxley | | | 4. DATE OF DEATH Month January Day 18 Year 19 58 | | |
| 5. SEX Male | 6. COLOR OR RACE B. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/8/1893 | | 9. AGE (In years last birthday) 64 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10b. KIND OF BUSINESS OR INDUSTRY Penn Sand Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Not Known | | | 14. MOTHER'S MAIDEN NAME Anna Moxley | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-07-1853 | | 17. INFORMANT Mrs. Kitty L. Moxley Address Hancock, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c) Phle | | | | | INTERVAL BETWEEN ONSET AND DEATH Phle |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | 20g. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from Jan 18, 19 58 to Jan 18, 19 58 that I last saw the deceased alive on Jan 18, 19 58 , and that death occurred at 11:15 AM from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE L.M. Sharfer M.D. | | | DATE SIGNED Jan 18, 19 58 | | |
| PHYSICIAN'S NAME (Type) L.M. Sharfer MD Hancock Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/20/1958 | | 22c. NAME OF CEMETERY OR CREMATORY River View Cemetery | |
| 22d. LOCATION (City, town, or county) (State) Hancock Washington Maryland | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Moore Hancock Md | | | 24a. REC'D BY REGISTRAR DATE JAN 21 '58 | | |
| 24b. REGISTRAR'S SIGNATURE Charles | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. 1

JAN 21 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1254

CERTIFICATE OF DEATH

01225

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|---|---------------------------|--|-------|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md RFD</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Maryland RFD 1</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home Inc.</u> | | | | d. STREET ADDRESS <u>Pinesburg</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Lucy</u> | | First | | Middle | | Last | |
| 4. DATE OF DEATH <u>Jan.</u> | | Month | | Day | | Year | |
| <u>9</u> | | <u>19</u> | | <u>58</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>-- 1872</u> | 9. AGE (In years last birthday) <u>85</u> yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT <u>Mr. John Eby Williamsport, Md RFD #2</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Chr. Endocarditis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> to <u>Jan. 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 9</u> , 19 <u>58</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state): <u>Clear Spring Md.</u> DATE SIGNED: <u>1/10/58</u> ACTUAL SIGNATURE: <u>David R. Brewer</u> M.D. PHYSICIAN'S NAME (Type): <u>David R. Brewer</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 12-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mennonite Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Pinesburg, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf</u> | | | | 24a. RECD BY REGISTRAR <u>Jan 14 58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Carl Smith</u> | |

ARKYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 11

14 Nov 1953

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01226

Reg. Dist. No.

| | | | | | |
|--|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY in 1b 2 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 W. Antietam St. | | | d. STREET ADDRESS 15 W. Antietam St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Carl Middle Theodore Last Myers | | | 4. DATE OF DEATH Month Jan. 11, Day 19 Year 58 | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 4, 1906 | 9. AGE (In years last birthday) 51 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk | | 10b. KIND OF BUSINESS OR INDUSTRY railroad | | 11. BIRTHPLACE (State or foreign country) Leitersburg, Md. | |
| 13. FATHER'S NAME John H. Myers | | | 14. MOTHER'S MAIDEN NAME Lottie Brown | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 705-10-5430 | | 17. INFORMANT Mildred Myers, Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic coronary heart disease 420.1 DUE TO coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) - | (County) - |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 1-13-58 | |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | 22b. DATE THEREOF 1-15-58 | 22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery | | 22d. LOCATION (City, town, or county) (State) Smithsburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md. | | ADDRESS Hagerstown, Md. | | 24a. REC'D BY REGISTRAR DATE JAN 16 '58 | 24b. REGISTRAR'S SIGNATURE [Signature] |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
HEALTH DEPT.

Washington

Hyattsville

2 years

Hyattsville

15 W. Anderson St.

15 W. Anderson St.

Male

Theodore W. Wynn

Jan. 11, 1906

White

Electric

John H. Wynn

Hotel Brown

705-10-2-30 Alfred Wynn, Hyattsville, Md.

BUREAU V. S.

JAN 16 1908

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1219

CERTIFICATE OF DEATH

01227

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY Franklin | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | | c. LENGTH OF STAY IN 1b 5 Weeks | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1222 Virginia Ave Martin-Mann Rest Home | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro 75X-3 | | | |
| 3. NAME OF DECEASED (Type or print) First Ida Middle Adz. Last Oller | | | | 4. DATE OF DEATH Month Jan. Day 8. Year 19 58 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 20, 1867 | |
| 9. AGE (In years last birthday) 90 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Near Rouzerville Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME John Downin | | | |
| 14. MOTHER'S MAIDEN NAME Susan Barkdoll | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Mr. J. Edgar Oller, Waynesboro Pa. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Head of pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio sclerosis | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Dec 9, 1957 , to Jan 8, 1958 , that I last saw the deceased alive on Jan 7, 1958 , and that death occurred at 10⁰⁰ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 217 W. Washington Street DATE SIGNED 1/8/58 | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto M.D. Waynesboro Pa. | | | | | | | |
| PHYSICIAN'S NAME (Type) Edward W. Ditto M.D. Hagerstown, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/11/58 | | 22c. NAME OF CEMETERY OR CREMATORY Green Hill | | 22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Hoar, Waynesboro Pa. | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE JAN 13 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. Hoar | | | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. 3.

8261 81 No:

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

01228

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 237 Jefferson St., | | d. STREET ADDRESS 237 Jefferson St., | |
| 3. NAME OF DECEASED (Type or print) First Minerva Middle Elizabeth Last Osborne | | 4. DATE OF DEATH Month 1 Day 23 Year 1958 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 8, 1898 |
| 9. AGE (In years last birthday) 59 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | |
| 11. BIRTHPLACE (State or foreign country) Wash. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Hetzer | | 14. MOTHER'S MAIDEN NAME Ann Moore | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT James M. Osborne | | Address Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition. Malnutrition. 286.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental condition for past 5 years. | | | INTERVAL BETWEEN ONSET AND DEATH About 6 months. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from September, 1953 to Jan. 23, 1958 , that I last saw the deceased alive on Jan. 7, 1958 , and that death occurred at 12:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 North Potomac St. Hagerstown, Md. DATE SIGNED 1-24-58 | | | |
| ACTUAL SIGNATURE <i>R. A. Bell</i> | | M.D. 119 North Potomac St. Hagerstown, Md. | |
| PHYSICIAN'S NAME (Type) R. A. Bell, M. D. | | Hagerstown, Maryland. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | 22b. DATE THEREOF 1-25-58 | 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | 22d. LOCATION (City, town, or county) (State) Hagerstown Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss | | ADDRESS Hagerstown, Md. | |
| 24a. REC'D BY REGISTRAR DATE JAN 27 '58 | | 24b. REGISTRAR'S SIGNATURE <i>W. H. ...</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|------------------------|--|------------------------|--|----------------------|--|-----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | |
| JAMES H. HARRIS | | Male | | 35 | | 1923 | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | |
| 1234 Baltimore St. | | Teacher | | Heart Disease | | Natural | |
| DATE OF DEATH | | PLACE OF DEATH | | HOURS OF DEATH | | TEMPERATURE | |
| Jan 27, 1958 | | Home | | 10:00 AM | | 98.6 | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| Jan 27, 1958 | | Jan 27, 1958 | | Jan 27, 1958 | | Jan 27, 1958 | |

BUREAU V. H.

JAN 27 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1255

CERTIFICATE OF DEATH

01229

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Rural</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Hagerstown</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2535 Penna. Ave</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Humphrey</u> Last <u>Paxson</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 2nd</u> | |
| 9. AGE (In years lost birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Lowdown County, Virginia</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | |
| 13. FATHER'S NAME <u>William Lodge Humphrey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rose Moore</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT Address <u>MR. JACK PAXSON HAGERSTOWN, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Carcinoma from Colon</u> DUE TO (c) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>1955</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u>o. 11</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>1956</u> , 19 <u>Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>29 Dec. 1957</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>135 N. Potomac St. HAGERSTOWN, MD.</u> DATE SIGNED <u>1 Jan. 1958</u> | | | | | | | |
| ACTUAL SIGNATURE <u>J. D. Wilson</u> M.D. <u>1 Jan. 1958</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>J. D. WILSON, MD</u> <u>135 N. Potomac St. HAGERSTOWN, MD.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>1/4/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u> | | 22d. LOCATION (City, town, or county) (State) <u>Round Hill Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hall Funeral Home</u> ADDRESS <u>Bearsville, Va</u> | | | | 24a. REC'D BY REGISTRAR <u>Jan 3 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>P. H. H. H. H.</u> | |

3 JAN 3 1953

BUREAU V. 8

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

01230

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 03 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL | | d. STREET ADDRESS 1452 JEFFERSON BLVD. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle LEONARD Last POOLE | | 4. DATE OF DEATH Month JAN. Day 18 Year 1958 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/3/06 |
| 9. AGE (In years last birthday) 51 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARETAKER | | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME CLARENCE W. POOLE | | 14. MOTHER'S MAIDEN NAME MARY VIRGINIA COLSON. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] UNKNOWN no | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Maggie Poole | | Address Jefferson Blvd | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIAC HYPERTROPHY & DILATATION DUE TO (c) CORONARY ATHEROSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 5 MOS. 5 MOS UNKNOWN | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA, HEALED MYOCARDIAL INFARCT. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from JAN. 17, 1958 to JAN. 18, 1958 , that I last saw the deceased alive on JAN. 18, 1958 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE George Beren, L.D. | | ADDRESS (Street, city or town, state) DATE SIGNED WESTERN MARYLAND STATE HOSPITAL 1/18/58 | |
| PHYSICIAN'S NAME (Type) DR. GEORGE BERCU | | HAGERSTOWN, MARYLAND. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 1-21-58 | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | 22d. LOCATION (City, town, or county) (State) Hagerstown Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Martin V. Pres. | | ADDRESS Hagerstown Md | |
| 24a. REC'D BY REGISTRAR — | | 24b. REGISTRAR'S SIGNATURE — | |
| DATE JAN 22 '58 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1256 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01231

Reg. Dist. No.

| | | | | | |
|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Downsville Md.</u> | | c. LENGTH OF STAY IN 1b <u>25 yrs.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Downsville Md.</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport RFD #1</u> | | | d. STREET ADDRESS <u>Williamsport RFD #1</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Roy Mc Kinley Price</u> | | | 4. DATE OF DEATH Month Day Year <u>Jan. 27 19 58</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 9 1897</u> | | 9. AGE (In years last birthday) <u>60 yrs.</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman Loom Fixer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Silk Mills</u> | | 11. BIRTHPLACE (State or foreign country) <u>Toledo Ohio</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> |
| 13. FATHER'S NAME <u>John W. Price</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary C. Price</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>World War</u> | | 16. SOCIAL SECURITY NO. <u>214 09 4953</u> | | 17. INFORMANT <u>Mrs. Lillian Price Williamsport Md RFD #1</u> | |

| | | | | | | | | |
|--|--|---|--|--|--|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 hrs</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>None</u> 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>Jan. 28. 58</u> | | |
| EXAMINER'S NAME (Type) <u>S. Robert WELLS M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 30-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Martinsburg W. Va.</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Lee Williamsport, Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 30 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Albert Lee</u> | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAN 30 1958

RECEIVED

1

1222

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 4 WEEKS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TILGHMANTON d. STREET ADDRESS BOONSBORO MD. ROUTE 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) IRENE MAY RAGER | | 4. DATE OF DEATH Month JANUARY Day 7 Year 1958 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH FEBRUARY 23 1876 |
| 9. AGE (In years last birthday) 84 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (State or foreign country) TILGHMANTON WASH.CO.MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JACOB MOATS | | 14. MOTHER'S MAIDEN NAME ANNIE MONGAN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT MISS PEARL MOATS BOONSBORO MD.R.1 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1/6/58 , 19 58 , to 1/7/58 , 19 58 , that I last saw the deceased alive on 1/7/58 , 19 58 , and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro Md. DATE SIGNED 1/7/58 ACTUAL SIGNATURE Robert Young M.D. William H. Young PHYSICIAN'S NAME (Type) William H. Young | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF JANUARY 9 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY MANOR CEMETERY NEAR TILGHMANTON WASH.CO.MD. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Paul - June Crow | | 24a. REC'D BY REGISTRAR DATE JAN 10 '58 | |
| 24b. REGISTRAR'S SIGNATURE Paul - June Crow | | | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU V. S.

IAN 10 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01233

1257

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>41 S. Main St.</u> | | | d. STREET ADDRESS <u>41 S. Main St.</u> | | |
| 3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>J.</u> Last <u>Reecher</u> | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>1</u> Year <u>1958</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/15/1875</u> | | 9. AGE (In years last birthday) <u>82</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer and</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fruit Grower</u> | | 11. BIRTHPLACE (State or foreign country) <u>Rouzeville Pa.</u> | |
| 13. FATHER'S NAME <u>David Reecher</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT <u>Mrs. Margaret R. Harbaugh, Smithsburg Md.</u> | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>10 Yrs.</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I attended the deceased from <u>8-9</u> , <u>1955</u> , to <u>1-1</u> , <u>1958</u> , that I last saw the deceased alive on <u>1-1</u> , <u>1958</u> , and that death occurred at <u>5:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | |
| ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D. | | | | | |
| PHYSICIAN'S NAME (Type) <u>Charles F. Hess M.D.</u> <u>Smithsburg, Md.</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/4/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg</u> | | 22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Washington Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Grove, Waynesboro Pa.</u> | | | 24a. REC'D BY REGISTRAR <u>AN 6</u> | | 24b. REGISTRAR'S SIGNATURE <u>A. Hedrick</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01234

1223

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|--|--------------------------------|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural Hancock Maryland.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u> | | | | d. STREET ADDRESS <u>Rural 1</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First <u>Dinah</u> Middle <u>Mae</u> Last <u>Ritchey</u> | | 4. DATE OF DEATH | | Month <u>1</u> Day <u>25</u> Year <u>19 58</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5.1.55</u> | | 9. AGE (In years last birthday) <u>2</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland Washington</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Clair Ritchey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eleanor M Barnhart</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Clair Ritchey R.F.D.1 Hancock Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>340.0 Meningitis, due to Hemophilus Influenza</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan. 24</u> , 19 <u>58</u> , to <u>Jan. 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 25</u> , 19 <u>58</u> , and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Archie Robert Cohen</u> | | | | ADDRESS (Street, city or town, state) <u>Clear Spring, Maryland</u> | | DATE SIGNED <u>1/27/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1.28.58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>McConnellsburg, Fulton Penna.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Shore</u> | | | | ADDRESS <u>Hancock Md</u> | | 24a. REC'D BY REGISTRAR <u>DATE JAN 31 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>W. J. Beach</u> | | | |

CONCISE

1258

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAUGANSVILLE | | | | c. LENGTH OF STAY IN 1b 8 YRS. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NORTH ST. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JACOB GUY SHADRACH | | | | 4. DATE OF DEATH JANUARY 12 19 58 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/15/1890 | 9. AGE (In years last birthday) 67 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STICHER | | 10b. KIND OF BUSINESS OR INDUSTRY SHOE CO. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JACOB U. SHADRACH | | | | 14. MOTHER'S MAIDEN NAME LAURA MONG | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. 214-09-3045 | | 17. INFORMANT MRS. BETTIE HYSSONG Address MAUGANSVILLE MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 33/X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vm. Accident DUE TO (c) Arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Muscular Dystrophy + Hypertension | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | Month, Day, Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I attended the deceased from 1956 , 19____, to 1/12 , 19 58 that I last saw the deceased alive on Jan 12 , 19 58 , and that death occurred at 20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 E. Patterson 1/13/58 DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Louis G. Guy | | M.D. Louis G. Guy | | | | | |
| PHYSICIAN'S NAME (Type) Louis G. Guy | | Hagerstown, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 1/14/58 | 22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | | 22d. LOCATION (City, town, or county) HAGERSTOWN MD. (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment ADDRESS Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 302

01236

1221

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Antietam Furnace</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u> | | d. STREET ADDRESS <u>none</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>ELMER</u> Last <u>SHAFFER</u> | | 4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>19 58</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 4, 1877</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stone Cutter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick Co., Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Solomon L. Shaffer</u> | | 14. MOTHER'S MAIDEN NAME <u>Susan E. Stouffer</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Mr. John Shaffer</u> | | Address <u>Hagerstown, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>28 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u></u> | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1-4-58</u> to <u>1-5-58</u> , that I last saw the deceased alive on <u>1-5-58</u> , 19 <u>58</u> , and that death occurred at <u>2:55 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert J. Ceadle</u> M.D. | | ADDRESS (Street, city or town, state) <u>1-6-58</u> DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <u></u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1/8/1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> | | ADDRESS <u>Hagerstown, Md.</u> | 24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u></u> |
| VS A15 (4) 15M 9/55 | | DATE JAN 13 '58 | |

MEDICAL CERTIFICATION

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BUREAU A. S.

AN 13 1958

RECEIVED

1259

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>25 West Church Street</u> | | | | d. STREET ADDRESS <u>25 West Church Street</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>M</u> Last <u>Shank</u> | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>19</u> Year <u>1958</u> | | 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 28 1884</u> | | 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR Months <u>10</u> Days <u>21</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | | 11. BIRTHPLACE (State or foreign country) <u>Welsh Run Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Holliday H. Shank</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Prudence Miller</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMY OR NAVY? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u> | | 17. INFORMANT Address <u>Mr. Edward Shank Williamsport Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obduracy Thrown Back</u> DUE TO <u>Immediate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u></u> a. m. <u>19</u> p. m. <u></u> Month <u></u> Day <u></u> Year <u></u> | | | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | |
| 20f. (City or town) <u></u> (County) <u></u> (State) <u></u> | | | | 21. I certify that I attended the deceased from <u>11/9/58</u> to <u>1/19/59</u> , that I last saw the deceased alive on <u>1/19/59</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above. | | | |
| 21. ADDRESS (Street, city or town, state) <u>Williamsport, Md.</u> | | | | 21. DATE SIGNED <u>1/19/59</u> | | | |
| ACTUAL SIGNATURE <u>William Shank</u> | | | | PHYSICIAN'S NAME (Type) <u>William Shank</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 22-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Western Pike Route 40 Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Shank</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 21 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>William Shank</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 show how to file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | | | | | | | | | |
|------------------|--|--------------|--|--------------|--|--------------|--|---------------|--|-----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1928 | | MOBILE, ALABAMA | |
| MARRIED | | SINGLE | | MARRIED | | SINGLE | | MARRIED | | SINGLE | |
| EDUCATION | | SCHOOLING | | SCHOOLING | | SCHOOLING | | SCHOOLING | | SCHOOLING | |
| HIGH SCHOOL | | HIGH SCHOOL | | HIGH SCHOOL | | HIGH SCHOOL | | HIGH SCHOOL | | HIGH SCHOOL | |
| UNIVERSITY | | UNIVERSITY | | UNIVERSITY | | UNIVERSITY | | UNIVERSITY | | UNIVERSITY | |
| COLLEGE | | COLLEGE | | COLLEGE | | COLLEGE | | COLLEGE | | COLLEGE | |
| POSTGRADUATE | | POSTGRADUATE | | POSTGRADUATE | | POSTGRADUATE | | POSTGRADUATE | | POSTGRADUATE | |
| PROFESSION | | PROFESSION | | PROFESSION | | PROFESSION | | PROFESSION | | PROFESSION | |
| BUSINESS | | BUSINESS | | BUSINESS | | BUSINESS | | BUSINESS | | BUSINESS | |
| LABORER | | LABORER | | LABORER | | LABORER | | LABORER | | LABORER | |
| OTHER | | OTHER | | OTHER | | OTHER | | OTHER | | OTHER | |

James Earl Ray

RECEIVED
 JAN 21 1963
 BUREAU V. 3

James Earl Ray

1225

CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pa. b. COUNTY Franklin | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | | c. LENGTH OF STAY IN 1b 6 Months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Conv. Home | | | | d. STREET ADDRESS 142 S. Potomac St. | | | |
| 3. NAME OF DECEASED (Type or print) First William Middle Franklin Last Sipe | | | | 4. DATE OF DEATH Month Jan. Day 6, Year 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 10, 1874 | |
| 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Office | | | | 10b. KIND OF BUSINESS OR INDUSTRY Landis Machine Co. | | 11. BIRTHPLACE (State or foreign country) Carlisle, Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Robert F. Sipe | | | | 14. MOTHER'S MAIDEN NAME Nancy Hagendorn | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No | | | | 16. SOCIAL SECURITY NO. 173-03-0894 | | 17. INFORMANT Dr. Edward Sipe, Waynesboro Pa. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thromboses 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 12/30/57 , 19 57 , to 12/30/57 , 19 57 , that I last saw the deceased alive on 12/30/57 , 19 57 , and that death occurred at 7:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 North Potomac St. Carlisle Pa. DATE SIGNED 1/8/58 | | | | | | | |
| ACTUAL SIGNATURE Howard N. Weeks | | | | M.D. Howard N. Weeks | | | |
| PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. | | | | Hagerstown, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/9/58 | | 22c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery | | 22d. LOCATION (City, town, or county) (State) Carlisle Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Kalter Z. Gove | | | | 24a. REC'D BY REGISTRAR DATE JAN 10 58 | | 24b. REGISTRAR'S SIGNATURE W. H. ... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 10 1958

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | | c. LENGTH OF STAY IN 1b life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 915 Chestnut St., | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Susan Middle M Last Slick | | | | 4. DATE OF DEATH Month 1 Day 10 Year 19 58 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-16-1878 | |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (State or foreign country) Middleburg Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Jonas B. Martin | | | | 14. MOTHER'S MAIDEN NAME Kathryn Martin (Boward) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Charles M. Slick Address Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 yrs DUE TO (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 12-20, 1957 to 1-10, 1958 that I lost saw the deceased alive on 1-7-58 , and that death occurred at 4 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J. Sw Oith | | | | DATE SIGNED 1/10/58 | | | |
| PHYSICIAN'S NAME (Type) J. Sw Oith | | | | M.D. Hagerstown Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | | | 22b. DATE THEREOF 1-13-58 | | 22c. NAME OF CEMETERY OR CREMATORY Rose Hill | |
| 22d. LOCATION (City, town, or county) (State) Hagerstown, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Address Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR DATE JAN 14 '58 | | 24b. REGISTRAR'S SIGNATURE Allen Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED JAMES M. HARRIS | | 2. SEX Male | |
| 3. AGE 45 | | 4. DATE OF BIRTH 1898 | |
| 5. PLACE OF BIRTH Baltimore, Md. | | 6. OCCUPATION Clerk | |
| 7. MARITAL STATUS Married | | 8. CAUSE OF DEATH Heart Disease | |
| 9. DATE OF DEATH Jan 14 1953 | | 10. PLACE OF DEATH Home | |
| 11. SIGNATURE OF DECEASED James M. Harris | | 12. SIGNATURE OF WITNESSES John J. Harris, Mary M. Harris | |
| 13. SIGNATURE OF PHYSICIAN Dr. J. M. Harris | | 14. SIGNATURE OF CORONER John J. Harris | |
| 15. SIGNATURE OF REGISTRAR John J. Harris | | 16. SIGNATURE OF CLERK John J. Harris | |

BUREAU V. S.

JAN 14 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01240

1227

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | d. STREET ADDRESS RT. #3 HAGERSTOWN | |
| 3. NAME OF DECEASED (Type or print) WILLIAM First HAMILTON Middle SNYDER Last JR. | | 4. DATE OF DEATH JANUARY Month 7 Day 19 Year 58 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/22/1890 |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EXECUTIVE | | 10b. KIND OF BUSINESS OR INDUSTRY METAL WKS. | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME WILLIAM H. SNYDER | |
| 14. MOTHER'S MAIDEN NAME VIRGINIA LINEBAUGH | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. 283-07-3477 | | 17. INFORMANT MRS. ELIZABETH W. SNYDER Address HAGERSTOWN RT. #3 MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding Duodenal Ulcer, Chronic DUE TO Cerebrovascular sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 years (c) | | | INTERVAL BETWEEN ONSET AND DEATH 1 month |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year 19 | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from Jan 55 to 7 Jan 58 , that I last saw the deceased alive on 7 Jan 58 , and that death occurred at 7:30 P M, from the causes and on the date stated above. | |
| ACTUAL SIGNATURE Paul Haak M.D. | | ADDRESS (Street, city or town, state) 28 W. Potomac Street DATE SIGNED 9 Jan 58 | |
| PHYSICIAN'S NAME (Type) PAUL HAAK, M.D. | | Williamsport, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 1/10/58 | 22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | 22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.J. Norment, Hagerstown, Md. | | 24a. REC'D BY REGISTRAR JAN 13 '58 DATE 9 Jan 58 24b. REGISTRAR'S SIGNATURE W. J. Norment | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 13 1938

BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01241

1228

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>943 Rose Hill Ave.</u> | | d. STREET ADDRESS <u>943 Rose Hill Ave.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Joyce</u> Middle <u>Marie</u> Last <u>Speaker</u> | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>19 58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 12 1957</u> |
| 9. AGE (In years last birthday) yrs. <u>6</u> Months <u>12</u> Days <u></u> Hours <u></u> Min. <u></u> | | 10. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Mr. Resley Speaker</u> | | 14. MOTHER'S MAIDEN NAME <u>Charlotte Shoemaker</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mr. Resley Speaker</u> | | Address <u>943 Rose Hill Ave Hagerstown Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Water house fire hidden by smoke</u> <u>057.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1/23/58</u> to <u>1/23/58</u> , that I last saw the deceased alive on <u>1/23/58</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u> DATE SIGNED <u>1/24/58</u> | | | |
| ACTUAL SIGNATURE <u>Dolph A. Young</u> M.D. | | PHYSICIAN'S NAME (Type) <u>William J. Ford</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 25-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Bakersville Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Bakersville Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Lou Williams</u> | | 24a. REC'D BY REGISTRAR <u>md</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>md</u> | | DATE <u>JUN 27 '58</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 2

8361 43 NY

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01242

1260

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md RFD #2</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Williamsport Md. RFD #2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Md. RFD #2</u> | | d. STREET ADDRESS <u>Bower Ave. Williamsport RFD2</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Earl Hager Spielman</u> | | 4. DATE OF DEATH Month Day Year <u>Jan. 22 1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 2 1882</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>20</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Tilghmanton Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George Spielman</u> | | 14. MOTHER'S MAIDEN NAME <u>Manzela Highbarger</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs. Elsie Walker</u> | | Address <u>Bower Ave. Williamsport Md RFD 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Exposure to Brown Kosi</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>None</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12/25/58</u> , 19 <u>58</u> , to <u>1/24/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/24/59</u> , 19 <u>59</u> , and that death occurred at <u>12/25/58</u> M, from the causes and at the date stated above. ADDRESS (Street, city, or town, state) <u>Williamsport Md</u> DATE SIGNED <u>1/24/59</u> ACTUAL SIGNATURE <u>Ralph T. Young</u> M.D. PHYSICIAN'S NAME (Type) <u>Ralph T. Young</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 25-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Manor Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Near Tilghmanton Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. L. Young</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 27 '58</u> | |
| ADDRESS <u>Williamsport, Md</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u> | |

CERTIFICATE OF DEATH

1864

Coroner's Office

BUREAU V. R.

JAN 27 1958

RECEIVED

1/27/58
1/27/58
1/27/58

1229

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | | c. LENGTH OF STAY IN 1b 16 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 505 Chestnut Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First RALPH Middle VICTOR Last STONE | | | | 4. DATE OF DEATH Month January Day 4 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 15, 1897 | 9. AGE (In years last birthday) 60 yrs. | IF UNDER 1 YEAR Months 5 Days 19 Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger | | 10b. KIND OF BUSINESS OR INDUSTRY Self Employed | | 11. BIRTHPLACE (State or foreign country) Edgemont, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Stone | | | | 14. MOTHER'S MAIDEN NAME Rose Harbaugh | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Ruth Stone Hagerstown, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4 pm , 19 58 , to 4 pm , 19 58 , that I last saw the deceased alive on 4 pm , 19 58 , and that death occurred at 3:00 P. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE F. F. Lusby | | | | ADDRESS (Street, city or town, state) 230 N. Plum Hagerstown Md. | | DATE SIGNED 6 Jan 58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/7/1958 | | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklin Rouzer | | | | ADDRESS Hagerstown, Md. | | 24a. REC'D BY REGISTRAR DATE JAN 13 1958 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Alfred Smith | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1, Film G22, 1-22-58 et

CERTIFICATE OF DEATH

01244

Reg. Dist. No. 302

1230

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>2 Weeks</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 Hagerstown</u> d. STREET ADDRESS <u>East Oak Ridge Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR GARMAN STOTELMYER</u> | | | | 4. DATE OF DEATH Jan Dec 14 1958 19 | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb 10 1900</u> | | 9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Mason</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>----</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md</u> <u>Downsville Wash. Co</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Harvey A. Stotelmeyer</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Flora May Baker</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-09-3968</u> | | 17. INFORMANT Address <u>Mrs Edna K. Stotelmeyer Hagerstown Md</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Hypertensive Cardio-Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> DUE TO <u>disease with uremia due</u> lying cause last. (c) <u>to Renal Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6-8 Mo-</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Mar 8, 1952</u> , to <u>Jan 14, 1958</u> , that I last saw the deceased alive on <u>Jan 14, 1958</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 W. Washington Street</u> <u>1/14/58</u> DATE SIGNED ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D. <u>1/14/58</u> PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> <u>Hagerstown, Maryland</u> <u>1/14/58</u> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/17/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Manor Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>near Tilghmanton Wash. Co Md</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>JAN 16 '58</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND AND STATE OF NEW YORK

ORIGINAL

BUREAU V. S.

JAN 16 1933

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01245**

| | | | | | |
|--|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 1 1/2 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 38 N. Potomac Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Everly's Department Store | | | d. STREET ADDRESS Hagerstown, Maryland | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First VIOLA Middle AMELIA Last STOUFFER | | | 4. DATE OF DEATH Month January Day 27 Year 19 58 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 7, 1885 | | 9. AGE (In years last birthday) 72 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Dept. Store | | 11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland | |
| 13. FATHER'S NAME Clinton S. Stouffer | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 14. MOTHER'S MAIDEN NAME Laura Siegrist | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | |
| 16. SOCIAL SECURITY NO. 214-09-7722 | | | 17. INFORMANT Mr. Clyde Stouffer Hagerstown, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Vascular Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) None | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None | |
| 20f. (City or town) - | | 20g. (County) - | | 20h. (State) - | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE S. Robert Wells | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | DATE SIGNED Jan. 28 '58 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/29/1958 | | 22c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery | |
| 22d. LOCATION (City, town, or county) Funkstown, Maryland | | 22e. (State) Md. | | 23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Rager | |
| 23. FUNERAL DIRECTOR'S ADDRESS Hagerstown, Md. | | 24a. REC'D BY REGISTRAR JAN 30 '58 | | 24b. REGISTRAR'S SIGNATURE W. L. ... | |

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHORE 18
MEAN AT EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

NAME OF DECEASED
SEX

DATE OF DEATH

PLACE OF DEATH

CITY

COUNTY

STATE

ZIP

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

CITY

COUNTY

STATE

ZIP

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

CITY

COUNTY

STATE

ZIP

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

CITY

COUNTY

STATE

ZIP

AGE

SEX

RACE

RELIGION

BUREAU V. S.

JAN 30 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Binford

1232

CERTIFICATE OF DEATH

01246

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | | c. LENGTH OF STAY IN 1b 1 month | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital | | | | e. STREET ADDRESS 36 South Cannon Ave. | | | |
| 3. NAME OF DECEASED (Type or print) NANNIE BOWERS STRINE First Middle Last | | | | 4. DATE OF DEATH January 6 19 58 Month Day Year | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 14, 1890 | |
| 9. AGE (In years last birthday) 67 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (State or foreign country) Berryville, Clarke Co. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Frank L. Hamilton | | | | 14. MOTHER'S MAIDEN NAME Virginia Jennie Hart | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mr. Walter K. Strine-36 S. Cannon Av. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) Arteriosclerotic Heart Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 weeks 5 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Aneurysm | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 7 Dec 1957 to 6 Jan 1958 , that I last saw the deceased alive on 5 Jan 1958 , and that death occurred at 8:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Richard T. Binford M.D. | | | | PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 1-8-58 | | 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | |
| 22d. LOCATION (City, town, or county) (State) Hagerstown, Wash. Co. Md. | | | | 23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland | | | |
| 24a. REC'D BY REGISTRAR DATE 8 '58 | | | | 24b. REGISTRAR'S SIGNATURE Debraich | | | |

BUREAU V. S.

8 JAN 8 1958

RECEIVED

1233

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | c. LENGTH OF STAY IN 1b — | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Conv. Hospital</u> | | d. STREET ADDRESS <u>5. Washington St.</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Margaret Rankin Strite</u> First Middle Last | | 4. DATE OF DEATH <u>Jan. 10</u> Day Year 19 <u>58</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/10/1875</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper & Clerk in Store</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Samuel J. Strite</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Belle Ruthrauff</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs. Jessie Shrader</u> | | Address <u>Greencastle, Pa.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio sclerotic heart disease with myocardial failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs +</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. p. m. <u>19</u> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1950</u> , 19____, to <u>10 Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 Jan</u> , 19 <u>58</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>F. F. Lusby</u> | | ADDRESS (Street, city or town, state) <u>230 N Poloma</u> | |
| PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u> | | DATE SIGNED <u>11 Jan 58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u> | 22b. DATE THEREOF <u>1/13/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich</u> | | ADDRESS <u>Greencastle, Pa.</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE JAN 14 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Quinn</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 11

BUREAU V. S.

JAN 14 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1234

CERTIFICATE OF DEATH

Reg. Dist. No.

01248
302

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 11 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co Hospital | | d. STREET ADDRESS 225 Mill Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Raymond Swanson Turner | | 4. DATE OF DEATH Month Day Year Jan. 23 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 22, 1902 |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance City Water Dept | | 10b. KIND OF BUSINESS OR INDUSTRY Shenandoah Page Co Va | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Turner | | 14. MOTHER'S MAIDEN NAME Ella V. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-38-8489 | |
| 17. INFORMANT Mrs Violet Manford | | Address 830 Hamilton Blvd | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Emphysema DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min 5 years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July , 19 55 , to 1/23 , 19 58 , that I last saw the deceased alive on 10 Am 1/23, 19 58 , and that death occurred at 9 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac St DATE SIGNED 1/24/58 | | | |
| ACTUAL SIGNATURE Paul Harrison | | M.D. Hagerstown, Md | |
| PHYSICIAN'S NAME (Type) PAUL HARRISON | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/25/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman | | ADDRESS Hagerstown Md. | |
| 24a. REC'D BY REGISTRAR JAN 28 '58 | | 24b. REGISTRAR'S SIGNATURE Alfred Smith | |

CERTIFICATE OF DEATH

BUREAU V. H.

JAN 28 1959

RECEIVED

CERTIFICATE OF DEATH

1235

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u> | | d. STREET ADDRESS <u>1215 Virginia Ave</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>JANE</u> Last <u>WAGELEY</u> | | 4. DATE OF DEATH Month <u>Jan</u> Day <u>25</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 4 1881</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Berkeley Cty., W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Newton Hutzler</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Burgess</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Mrs. Naomi Robinson</u> | | Address <u>664 Pin Oak Rd Hagerstown, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central thrombosis due to</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>1-2 yrs.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb 25, 1952</u> to <u>Jan 25, 1958</u> , that I last saw the deceased alive on <u>Jan 23, 1958</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edward W. Dittus, M.D.</u> | | DATE SIGNED <u>1/25/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Edward W. Dittus, M.D.</u> | | <u>217 W. Washington St Hagerstown, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-28-1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>New Norborne Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Martinsburg, Berkeley, W. Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> | | ADDRESS <u>Hagerstown, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>Jan 28 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Deborah</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1261

CERTIFICATE OF DEATH

01250

Reg. Dist. No.

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|---|----------------------------------|---|---|---|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg | | c. LENGTH OF STAY IN 1b 45 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD 1 | | | | d. STREET ADDRESS RFD 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) James Stanley Webb | | | 4. DATE OF DEATH Jan. 7, 1958 | | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 25, 1912 | | 9. AGE (In years last birthday) 45 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY iron works | | 11. BIRTHPLACE (State or foreign country) Smithsburg, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Samuel F. Webb | | | 14. MOTHER'S MAIDEN NAME Jennie Brown | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWII | | 16. SOCIAL SECURITY NO. 219001-9615 | | 17. INFORMANT Samuel F. Webb, Smithsburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Renal disease 442x DUE TO This may have been treated by Dr. B.B. Kennedy for 6 yrs. He is out of town. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 yrs | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. p. m. _____ Month, Day, Year _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 1-7 , 19 57 , to 1-7 , 19 58 that I last saw the deceased alive on 1-7 , 19 57 , and that death occurred at 1:45 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Robert P. Conrad | | ADDRESS (Street, city or town, state) 137 W. Washington, Hagerstown, Md. DATE SIGNED Mar 15, 58 | | | | | |
| PHYSICIAN'S NAME (Type) Robert P. Conrad, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 1-9-58 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Cemetery | | 22d. LOCATION (City, town, or county) (State) Garfield, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md. | | | | 24a. REC'D BY REGISTRAR JAN 13 '58 | | 24b. REGISTRAR'S SIGNATURE Robert P. Conrad | |

BUREAU V. S.

RECEIVED
JAN 13 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1236

CERTIFICATE OF DEATH

Reg. Dist. No. 302

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|---|---|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | c. LENGTH OF STAY IN 1b <u>1 week</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u> | | d. STREET ADDRESS <u>918 Rose Hill Cemetery</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>ALBERT</u> Last <u>WELLER</u> | | 4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 28 1897</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u> | 11. BIRTHPLACE (State or foreign country) <u>Funkstown Wash. Co Md.</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Jamison poor co</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Frank Weller</u> | | 14. MOTHER'S MAIDEN NAME <u>Clara Stockslager</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-09-4037</u> | |
| 17. INFORMANT <u>Mrs Elsie K. Weller</u> | | Address <u>918 Rose Hill Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>490X</u> DUE TO <u>Lobar Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis; Hypertension</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. _____ p. m. _____ | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>26 Dec., 1957</u> , to <u>1 Jan., 1958</u> , that I last saw the deceased alive on <u>1 Jan., 1958</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Richard T. Binford</u> | | ADDRESS (Street, city or town, state) <u>1135 POTOMAC AVE.</u> | |
| PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD</u> | | DATE SIGNED <u>2 JAN. 58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/3/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetery</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> | | 24a. REC'D BY REGISTRAR <u>6</u> | |
| ADDRESS <u>Hagerstown Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u> | |

CERTIFICATE OF DEATH

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| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. CAUSE OF DEATH | | 8. PLACE OF DEATH | | 9. TIME OF DEATH | | 10. SIGNATURE OF PHYSICIAN | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF WITNESSES | |
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1237

Reg. Dist. No. 01252

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 30 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In Cab of Cabosse - on Pa. R.R. Tracks | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown | |
| 3. NAME OF DECEASED (Type or print) Charles Jeffery Wiles | | d. STREET ADDRESS 213 Summer St | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 31, 1911 | |
| 9. AGE (In years last birthday) 46 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor | | 12. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 13. BIRTHPLACE (State or foreign country) Brunswick Md. | | 14. CITIZEN OF WHAT COUNTRY? | |
| 15. FATHER'S NAME Roy L. Wiles | | 16. MOTHER'S MAIDEN NAME Lydia E. Garlack | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 18. SOCIAL SECURITY NO. W. W. 11 440-53-1996 | |
| 19. INFORMANT Mrs. Margaret Wiles | | Address Hagerstown Md. | |
| 20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterioasclerotic coronary heart disease DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) (County) (State) - - - | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE S. Robert Wells M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Samuel R. Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 1-27-58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-28-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son | | ADDRESS Hagerstown Md. | |
| 24a. REC'D BY REGISTRAR JAN 29 '58 | | 24b. REGISTRAR'S SIGNATURE Al. Lewis | |

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Washington

Washington

Washington

Washington

30 years

213 Summer St.

Jeffery Wiles

Charles

213 Summer St.

48

White female, born May 11, 1911

White

Washington, D.C.

Washington, D.C.

Washington, D.C.

Wanda S. Leland

Ray L. Wiles

Yes

W. W. 11

440-33-1990 Mrs. Margaret Wiles Washington, D.C.

BUREAU V. 2

JAN 29 1938

RECEIVED

George H. Gansert

1-28-38

George H. Gansert

George H. Gansert & Son, Washington, D.C.

1262
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75X-3 Rural - Chambersburg RD 5</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home</u> | | d. STREET ADDRESS <u>Chambersburg RD 5</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>C.</u> Middle <u>Wilson</u> Last | | 4. DATE OF DEATH <u>Jan.</u> Month <u>21</u> Day <u>1958</u> Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/29/1867</u> |
| 9. AGE (In years last birthday) <u>90</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Welsh Run, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James K. Wilson</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Hunter</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Mrs. Frank Carbaugh - Hagerstown, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Endocarditis</u> DUE TO (c) <u>5 yrs.</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 27, 1956</u> to <u>Jan 21, 1958</u> that I last saw the deceased alive on <u>Jan 20, 1958</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>David R. Brewer</u> M.D. | | ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>1/21/58</u> | |
| PHYSICIAN'S NAME (Type) <u>David R. Brewer</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u> | 22b. DATE THEREOF <u>1/24/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u> | 22d. LOCATION (City, town or county) (State) <u>Hagerstown, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Munnich</u> ADDRESS <u>Greencastle, Pa.</u> | | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE <u>Overhach</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: *William H. Brown*
AGE: *45*
SEX: *Male*
DATE OF DEATH: *Jan 21 1958*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Chronic Endocarditis*
DISEASE OR INJURY: *Chronic Endocarditis*
PERMANENT DAMAGE: *None*
MANNER OF DEATH: *Natural*
SIGNATURE OF PHYSICIAN: *David R. Brewer*
DATE: *Jan 21 1958*

BUREAU V. 1

JAN 23 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01254

1268

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Bonnsboro R.F.D. | | c. LENGTH OF STAY IN 1b 3 Months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro 75X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION F. hrney-Keedy Home | | | | d. STREET ADDRESS 237 S. Church St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ira Middle Laban Last Wingert | | | | 4. DATE OF DEATH Month Jan. Day 5 Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 22, 1881 | | 9. AGE (In years last birthday) 76 yrs. | IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Custodian | | 10b. KIND OF BUSINESS OR INDUSTRY Machinist | | 11. BIRTHPLACE (State or foreign country) Waynesboro Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Rev. Laban W. Wingert | | | | 14. MOTHER'S MAIDEN NAME Prudence Stover | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 173-03-3777 | | 17. INFORMANT Mrs. John C. Toms, 237 S. Church St., Waynesboro | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. 11. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 5, 1957 , to January 5, 1958 , that I last saw the deceased alive on January 4, 1957 , and that death occurred at 6 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bonnsboro DATE SIGNED 1-5-58 ACTUAL SIGNATURE G. W. LeVan M.D. Med. PHYSICIAN'S NAME (Type) G. W. LeVan M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/8/58 | | 22c. NAME OF CEMETERY OR CREMATORY Green Hill | | 22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Halton J. Love | | | | 24a. REC'D BY REGISTRAR DATE JAN 8 '58 | | 24b. REGISTRAR'S SIGNATURE W. LeVan | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1264

CERTIFICATE OF DEATH

Reg. Dist. No.

01255

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> ✓ | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hancock Rest Home</u> | | d. STREET ADDRESS <u>129 So. Liberty St.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Wolford</u> Last <u>Wolford</u> | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>16</u> Year <u>19 58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 18, 1874</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | 11. BIRTHPLACE (State or foreign country) <u>Ridgeley, W. Va.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>Charles Ridgeley</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Elizabeth Thrasher</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mrs. Carl Goetz, 1902 Bedford St. Cumberland, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>561.3 Ventral hernia</u> DUE TO (b) <u>Strangulation</u> DUE TO (c) <u>about 4 yrs</u> 3 Days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u> |
| 21. I certify that I attended the deceased from <u>Nov 1</u> , 1957, to <u>Jan 10</u> , 1958, that I last saw the deceased alive on <u>Jan 15</u> , 1958, and that death occurred at <u>11:30 p. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>H. E. Tabler</u> | | DATE SIGNED <u>Hancock, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>H. E. Tabler</u> | | <u>Hancock, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Jan. 19, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> | | ADDRESS <u>Cumberland, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u> </u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 8

JAN 31 1958

RECEIVED

Reg. Dist. No. 302

1238

| | | | | | |
|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland | | b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown/ Baltimore 13 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home | | d. STREET ADDRESS 1737 Lombard St., East | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LOUIS | | First KARL | | Middle ZACHOW | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH March 27, 1870 | | 9. AGE (In years lost birthday) 87 yrs. | | IF UNDER 1 YEAR Months 9 Days 16 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Louis Karl Zachow | | 14. MOTHER'S MAIDEN NAME Paulina Schmidt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Rev. Mark Wagner | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20d. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10-1-1977 , to 1-13-1978 , that I last saw the deceased alive on 1-3-58 , and that death occurred at 4:47 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 1/13/58 ACTUAL SIGNATURE S. E. Smith M.D. S. E. Smith PHYSICIAN'S NAME (Type) S. E. Smith | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/15/1958 | | 22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery | |
| 22d. LOCATION (City, town, or county) (State) Baltimore Maryland | | 23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home | | 24a. REC'D BY REGISTRAR DATE JAN 15 '58 | |
| 24b. REGISTRAR'S SIGNATURE Alfred | | 24c. REGISTRAR'S NAME Alfred | | 24d. REGISTRAR'S ADDRESS Hagerstown, Md. | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

RECEIVED
BUREAU V. 1
 JAN 15 1958

| | | | | | |
|---|--|---|--|---|--|
| NAME OF DECEASED [Faint, illegible text] | | SEX [Faint, illegible text] | | AGE [Faint, illegible text] | |
| RACE [Faint, illegible text] | | DATE OF BIRTH [Faint, illegible text] | | PLACE OF BIRTH [Faint, illegible text] | |
| OCCUPATION [Faint, illegible text] | | CAUSE OF DEATH [Faint, illegible text] | | MANNER OF DEATH [Faint, illegible text] | |
| PLACE OF DEATH [Faint, illegible text] | | DATE OF DEATH [Faint, illegible text] | | TIME OF DEATH [Faint, illegible text] | |
| SIGNATURE OF PHYSICIAN [Faint, illegible text] | | SIGNATURE OF CORONER [Faint, illegible text] | | SIGNATURE OF REGISTRAR [Faint, illegible text] | |

1265

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | | | | | |
|---|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown | | | | c. LENGTH OF STAY IN 1b 40 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 Poplar Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First SUSAN Middle ZIMMERMAN Last ZIMMERMAN | | | | 4. DATE OF DEATH Month January Day 20 Year 1958 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 4, 1877 | 9. AGE (In years last birthday) 80 yrs. | IF UNDER 1 YEAR Months 5 Days 16 | IF UNDER 24 HRS. Hours 16 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Halfway, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Monroe Zimmerman | | | | 14. MOTHER'S MAIDEN NAME Leah Bitner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Miss. Katherine Zimmerman Funkstown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of stomach. DUE TO (b) (Gastrojejunostomy on Oct. 23, 1957) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 mos. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month. 19 Day. 19 Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 23, 1957 , to Jan. 20, 1958 , that I last saw the deceased alive on January 19, 1958 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 North Potomac St. Hagerstown, Maryland. DATE SIGNED 1-20-58 | | | | | | | |
| ACTUAL SIGNATURE R. A. Bell M.D. | | | | PHYSICIAN'S NAME (Type) R. A. Bell, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/22/1958 | | 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklin Poyner | | | | ADDRESS Hagerstown, Md. | | 24a. REC'D BY REGISTRAR DATE 2 2 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Quilley | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

4N 28 1958

RECEIVED